Hamilton Niagara Haldimand Brant **LHIN** | **RLISS** de Hamilton Niagara Haldimand Brant

Dramatically Improving the Patient Experience through Quality, Integration and Value

2016-2017 Annual Report

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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Vision, Mandate, Mission and Values

Vision

A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Mandate

To plan, fund and integrate the local health system to provide appropriate, coordinated, effective and efficient health services in Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk.

Mission

To ensure availability of, and access to, linked services in order to improve the health of the population and the continuity of health care.

Values

Respect; Integrity; Accountability

We work from the approach of being a catalyst for change; with a viewpoint based on the individual, and their caregivers, who need access to local health services.

To achieve this we are committed to: Transparency; Collaboration; Innovation; Real Conversation

Message from the CEO and Chair

Each year, the Annual Report serves as an opportunity to highlight a year's worth of accomplishments and share with our community all that has been achieved and touch on work still underway.

With the December 2015 release of *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, it was apparent that 2016-17 would be a year like no other for the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN). Initially intended to promote dialogue and generate feedback from health system users and stakeholders, the discussion paper also crystalized the Government's commitment to moving forward with significant structural changes to Ontario's health system that were first hinted at in the *Patients First: Action Plan for Health Care*.

In anticipation of the introduction and subsequent passage of the *Patient's First Act, 2016*, the LHIN devoted considerable time working closely with our colleagues at the Ministry of Health and Long-Term Care and the Hamilton Niagara Haldimand Brant Community Care Access Centre (HNHB CCAC) to ensure we were ready for our proposed new mandate. As we prepared for the forthcoming changes, we ensured we did not lose sight of the day-to-day business of the LHIN. The overarching goals of the *Patients First Act, 2016*, align closely with our Strategic Health System Plan (SHSP), which has guided our work since 2012 and ensured we remain focused on our strategic aim and strategic directions.

Strategic Aim

Dramatically improving the patient experience through Quality, Integration and Value.

Strategic Directions

1. Dramatically improving the patient experience by embedding a culture of quality throughout the system.
2. Dramatically improving the patient experience by integrating service delivery.
3. Dramatically improving the patient experience by evolving the role of the LHINs to become health system commissioners.

While there is a still much work to do, we are proud of the significant steps in the right direction that have been taken. Here are just a few of the notable accomplishments you'll read more about in the pages ahead:

- Following consultations with health system users, providers and other stakeholders, six **LHIN sub-regions** were identified and established. By looking at care patterns through a smaller, more local lens, the LHIN will be able to better identify and respond to community needs and ensure that patients across the LHIN have access to the care they need, when and where they need it.

- **Patient Experience** continued to be a primary focus, and this year, the LHIN required all providers to collect and report information on patient experience. Amongst the patients and caregivers surveyed, 88.5% responded favourably when asked about overall satisfaction with their care and 84.8% responded favourably when asked about their involvement in care decisions.

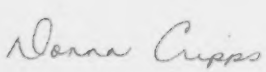
- The expansion of the **Transitional Care Program** continued in 2016-17 to include a total of 205 beds across 15 sites in Hamilton, Burlington, Niagara and Brant communities. Since its inception, the Program has reported 2,009 admissions resulting in 97,168 avoided hospital Alternate Level of Care (ALC) days.

- The LHIN continued to support increased and broadened access to **Indigenous Cultural Safety** (ICS) training as an educational platform contributing to improved cultural safety across the health care system. In 2016-17, a total of 316 individuals participated in ICS training including staff from the LHIN and 50 different health service providers.

As you can see from these examples, we are not doing this work alone. The HNHB LHIN staff and Board rely heavily on our health care partners across the region and we are grateful for their dedication to improving the delivery of health care. We are committed to supporting our partners and sharing their innovative work and successes through the voices and experiences of patients, clients, and caregivers.

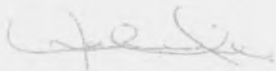
We look forward to continuing our journey together as we strive to create a health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren. The work we are doing is dramatically improving the patient experience - thank you for keeping our patients and their families at the centre of your thinking and your work.

Sincerely,



Donna Cripps

Chief Executive Officer

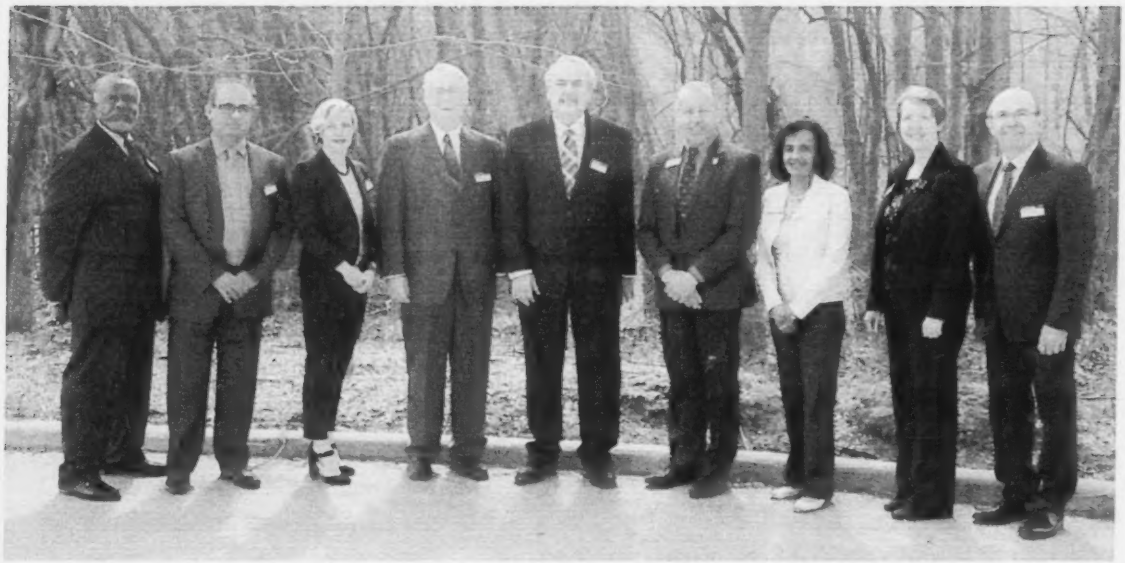


Janine van den Heuvel

Board Chair

The HNHB LHIN Board of Directors

(as of March 31, 2017)



From left to right: *Mervin Witter, Saqib Cheema, Janine van den Heuvel, Bill Thompson, William Chopp, Paul Armstrong, Madhuri Ramakrishnan, Laurie Ryan-Hill, Dominic Ventresca*

Janine van den Heuvel, Chair*
Appointed June 30, 2016 Term: 3 years

Mervin Witter, Vice Chair**
Appointed June 2, 2011 Term: 3 years
Re-appointed June 2, 2014 Term: 3 years

Laurie Ryan-Hill, Vice Chair***
Appointed May 17, 2011 Term: 3 years
Re-appointed May 17, 2014 Term: 3 years

Bill Thompson, Member
Appointed May 13, 2015 Term: 3 years

Dominic Ventresca, Member
Appointed May 27, 2015 Term: 3 years

Madhuri Ramakrishnan, Member
Appointed February 24, 2016 Term: 3 years

Paul Armstrong, Member
Appointed November 28, 2016 Term: 3 years

Saqib Cheema, Member
Appointed February 2, 2017 Term: 3 years

William Chopp, Member
Appointed March 1, 2017 Term: 3 years

*Appointed Chair March 22, 2017
**Appointed Vice Chair effective March 19, 2016
***Appointed Second Vice Chair effective March 30, 2016

Transitions in Board Membership

Helen Mulligan completed two three-year terms on the Board of Directors and ended her term on June 16, 2016.

Having completed the allowable two three-year terms, Board Chair Michael Shea ended his tenure with the LHIN on October 26, 2016. Michael was a valued member of the Board who also served as Nominating Committee Chair, and CEO Performance and Compensation Working Group Chair.

With Michael's departure from the Board, Laurie Ryan-Hill was appointed as Acting Board Chair, Nominating Committee Chair, and Chair of the CEO Performance and Compensation Working Group Chair and continued in this role until March 21, 2017.

On March 22, 2017, Janine van den Heuvel was appointed as Board Chair. Janine was appointed as a Board Member on June 20, 2016. Janine is also the chair of the Nominating Committee and chair of the CEO Performance and Compensation Working Group.

Relationship Between the Board and Leadership Team

As of March 31, 2017, the HNHB LHIN Leadership Team included the CEO and Directors of Communications, Community Engagement and Corporate Services; Health System Transformation; Access to Care; Quality and Risk Management; Finance; Health Links and Strategic Initiatives; and Physician Lead, Clinical Health System Transformation.

Leadership Team members attend the regular Board business meetings, including the Audit, and Quality and Safety Committees, and Board education meetings, as well as present monthly verbal and written reports to the Board on the activities in their respective portfolios.

Led by the CEO, and guided by the five-year Strategic Health System Plan (SHSP), three-year Integrated Health Service Plan (IHSP) and Annual Business Plan (ABP), the Leadership Team is responsible for the strategic operations of the organization and ensures the strategic aim and directions of the SHSP are at the forefront of the planning, integration and funding recommendations to the Board.

The Board provides ongoing direction to the CEO through:

- Regular business and education meetings;
- Board committees;
- Policy direction; and,
- Performance appraisal.

Continued Evolution of the HNHB LHIN

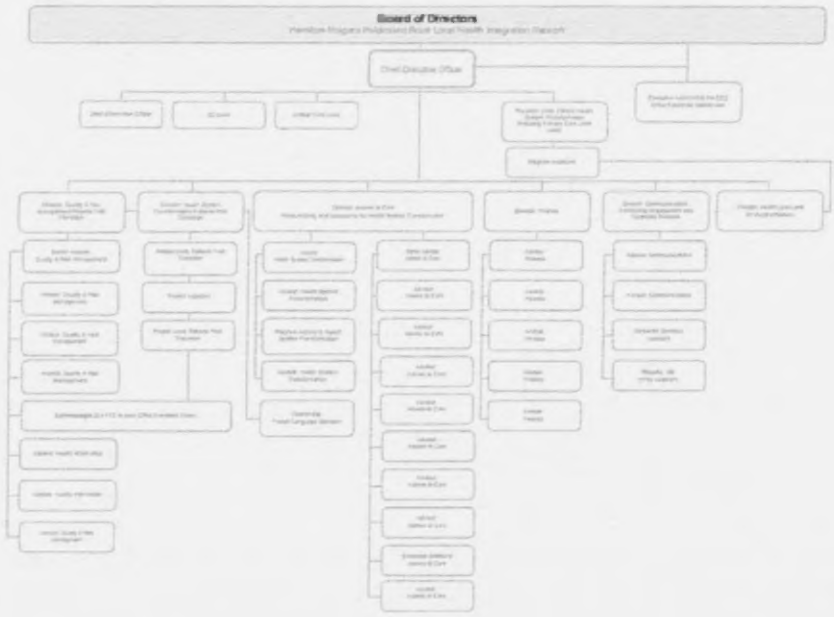
Our Organization

HNHB LHIN staff is committed to, and passionate about, working toward achieving the LHIN vision - a health care system that helps keep people healthy, gets them good care when they're sick, and will be there for our children and grandchildren – and the LHIN's strategic aim of dramatically improving the patient experience through quality, integration and value. It is this vision and strategic aim that guide staff in carrying out the duties of their roles.

The structure of roles within the organization is based on the core functions of the LHIN for the period of this report and maximizes the skills, knowledge and expertise of staff. Staff is committed to building capacity and knowledge sharing through participation in local, provincial, and national activities. Staff is guided by the values and principles of the organization including respect, integrity and accountability and to achieve this, staff is committed to transparency, collaboration, innovation and real conversations.

Throughout 2016-17, staff has committed and contributed to the transformation necessary to action Patients First. To ensure the successful implementation of the activities required for the transition of CCAC to the LHIN, development of sub-regions, engagement with Public Health, Primary Care, and our communities, a few focused and dedicated resources were required. The HNHB LHIN established the Patients First Transition Team to take the lead on accomplishing these activities. The team was comprised of current LHIN staff redeployed for a time-limited duration, in part or full, to work on Patients First.

Figure 1 – HNHB LHIN Organizational Chart

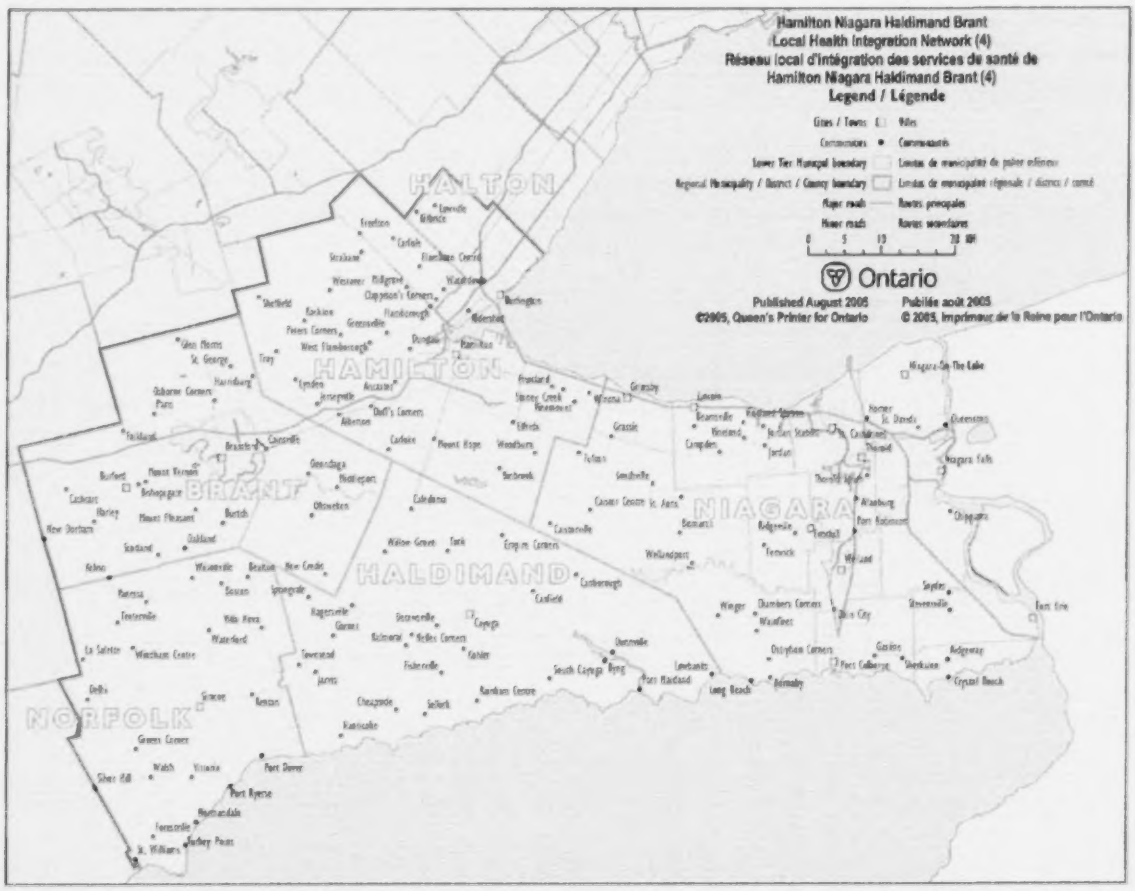


HNHB LHIN Population

Demographics

The HNHB LHIN encompasses both rural and urban areas and is approximately 7,145 km^2 in size. The LHIN is home to approximately 1.46 million people or 10.6% of the population of Ontario and is projected to grow 7.4% over the next 10 years *(Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).*

Figure 2 – HNHB LHIN Map



Socio-Demographic Characteristics

The LHIN's population is aging. More than 260,000 people age 65 or older live in the LHIN and this number is projected to increase to approximately 360,000 by 2025 – that is an increase of more than 35%. Among seniors, the largest growth will be those 75 years and older *(Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).*

The HNHB LHIN has a diverse population. For 17% of residents, neither English nor French is their first language. Francophone, First Nations, Inuit, Métis, and urban Indigenous people are recognized

populations in the HNHB LHIN. Compared to the Ontario average, the HNHB LHIN has a lower percentage of immigrants (19%) and visible minorities (10%) *(Source: National Household Survey, Statistics Canada, 2011).*

About 2.2% of the LHIN population is defined as Francophone. Almost 80% of the LHIN's Francophone population resides in Hamilton and Niagara. Niagara, Welland and Port Colborne have the highest percentage of Francophone populations compared to the overall population among communities within the LHIN *(Source: 2011 Census of Canada, Statistics Canada).*

There are two First Nations reserves in the LHIN – Six Nations of the Grand River Territory, which has the largest population of all First Nation communities in Canada, and Mississaugas of the New Credit First Nation. The total population who identify as Indigenous is approximately 36,955 people *(Source: National Household Survey, Statistics Canada, 2011).*

In many ways, the LHIN population is similar to the provincial population on a variety of socio-demographic characteristics. Within the LHIN however, there are some significant differences between and within geographic regions. While the HNHB LHIN has a similar population proportion of low-income families as Ontario, Hamilton rates of low income are higher than the provincial average. Compared to the Ontario average, the LHIN has a higher percentage of lone parent families and a lower percent of adults with high school and post-secondary education.

Figure 3 – HNHB LHIN Socio-Demographic Characteristics

Socio-Demographic Characteristic	HNHB LHIN	Ontario
Total Population (2015)*	1,458,453	13,792,053
Senior population, age 65+ (2015)*	18.3%	16.0%
Population who report English as their mother tongue	81.2%	70.3%
Population who report French as their mother tongue	2.2%	4.4%
Population who are immigrants	19.3%	28.6%
Populations who are visible minorities	10.3%	25.9%
Population reporting Indigenous identity	2.7%	2.3%
Unemployment rate	5.1%	8.3%
% Population living below low income measure	13.2%	13.8%
Population (age 25-64) with completed post-secondary education	61.3%	64.8%

*(Sources: *Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO; Remaining indicators based on 2011 Census of Canada and 2011 National Household Survey, Statistics Canada.)*

Health Status

Health can be measured as perceived or self-reported indicators as well as the presence or absence of disease or injury. Self-reported health can show aspects of health not captured in other measures. More than 13% of LHIN residents rate their health as 'fair' or 'poor', which is higher than Ontario's rates. In addition, more LHIN residents say they are limited in their activities because of a physical or mental condition or health problem and have pain or discomfort that prevents them from engaging in activities *(Source: Statistics Canada, Canadian Community Health Survey, 2013).*

Illness, Disease and Death

LHIN residents have a higher prevalence of high blood pressure, chronic obstructive pulmonary disease (COPD), and arthritis compared to the province. Approximately 20% of HNHB LHIN residents have been diagnosed with high blood pressure or arthritis, and 6% with COPD. The percentage of residents with asthma is 8% and diabetes is nearly 8%, which means that the HNHB LHIN rates are slightly higher than Ontario rates *(Source: Statistics Canada, Canadian Community Health Survey, 2011-12).*

Death rates reflect the overall health of the population. Ischemic heart disease, dementia and Alzheimer disease, lung cancer, and stroke were the top four leading causes of death in the HNHB LHIN. Potential years of life lost rates are useful for measuring the number of years of life "lost" from deaths that occur "prematurely" (i.e. before age 75). The rate of potential years of life lost within the HNHB LHIN is 11% higher than the provincial rate *(Source: Statistics Canada, 2011; CIHI Health Indicators Interactive Tool, 2010).*

Health Practices and Preventive Care

Poor health practices, such as physical inactivity or poor dietary habits, may increase the risk of chronic disease, disability, and death. The rate of smoking is 24% in the HNHB LHIN. This is the highest rate in the province and is significantly higher than the provincial average of 18%. However, the rates vary significantly within the LHIN from 9.9% in Ancaster to 37% in the Hamilton Urban Core. Relative to the province, more people in the HNHB LHIN have a body mass index (BMI) indicating they are overweight or obese. *(Source: Statistics Canada, Canadian Community Health Survey, 2013).* In 2013, there was a slightly lower percentage of adults in the HNHB LHIN reporting that their alcohol consumption was heavy when compared to the provincial average.

Activities that promote health, prevent disease and reduce the risk of injury are important elements in the health and wellness of a population. These activities require individuals to be engaged in their health care and can be facilitated through an effective relationship with a primary physician. More than 95% of adults living in HNHB LHIN reported having a primary care provider, which is slightly higher than the Ontario rate. Preventive health care services, such as immunizations and regular health screenings, can help prevent and find disease early and reduce illness and death over the long-term. Approximately 33% of HNHB residents received a flu shot in 2013, which is similar to the Ontario average *(Source: Health Care Experience Survey, Ministry of Health and Long-Term Care, 2014).*

Summary

Relative to Ontario, the LHIN has a significantly higher percentage of:

- People reporting health as 'fair' or 'poor'
- People reporting activity limitations due to pain or discomfort
- People with a BMI indicating they are overweight or obese
- People who smoke on occasional or daily basis
- People diagnosed with arthritis
- People diagnosed with COPD
- People diagnosed with high blood pressure
- People diagnosed with asthma
- People diagnosed with diabetes
- People reporting mental health as 'fair' or 'poor'
- Potential years of life lost from preventable causes
- Premature mortality and potentially avoidable mortality
- Ambulatory care sensitive conditions

HNHB LHIN-funded Health Service Providers

As of March 31, 2017, the HNHB LHIN held 188 Service Accountability Agreements with health service providers (HSPs) – including nine hospital corporations, 86 long-term care homes, and 93 community support service agencies - funding them to deliver health care services within the LHIN.

Engaging our Communities

Community engagement is a core function of Ontario's LHINs and is written into the *Local Health System Integration Act (LHSIA), 2006* – the legislation that created LHINs. As part of its work, the HNHB LHIN engages a diverse range of people, including residents, health professionals, and those who are actively involved in the health system. This includes engaging with members of the Indigenous and Francophone communities. The LHIN recognizes, respects, and seeks to understand and address the unique needs of its diverse communities.

In January and February 2016, following the release of *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, the HNHB LHIN engaged numerous stakeholders on behalf of the Ministry to solicit comments and feedback related to the proposal. The feedback was shared with the Ministry and was used to inform continued engagement and consultation with stakeholder groups in 2016-17, including a deliberate focus on primary care providers.

During the months of July and August 2016, the LHIN hosted a series of engagement sessions to share details related to the provincial government's *Patients First: Action Plan for Health Care,* including the development of sub-regions and an overview of the original Patients First bill. The LHIN held 13 engagement sessions with more than 200 participants. This included five webinars for all interested individuals, three webinars for primary care providers, including physicians, and two symposiums for health service providers and physicians. The LHIN also met with French language service providers, as well as took part in meetings with health service providers from our Indigenous communities.

Based on these extensive conversations and engagement with stakeholders and physicians, HNHB LHIN staff put forward six proposed sub-regions: Burlington, Hamilton, Brant, Haldimand Norfolk, Niagara and Niagara North West. The six proposed sub-regions were endorsed by the Board at the September 28, 2016 meeting and approved by the Ministry on January 16, 2017.

Materials and feedback from these engagement sessions including the slide decks, a recorded version of the webinar and presentations delivered to the Board are available on the LHIN website at http://www.hnhblhin.on.ca/PatientsFirst.aspx.

Indigenous Health Engagement and Inclusion

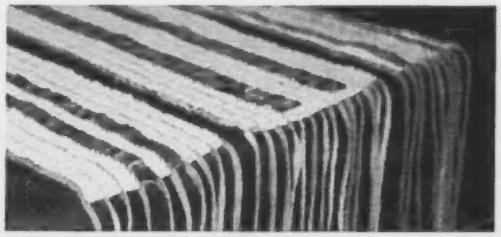
Listening and learning from Indigenous Peoples and communities allows the HNHB LHIN to maintain a strong focus on the holistic needs of Indigenous Peoples and how these needs can be harmonized with mainstream programs and services.

Throughout 2016-17, the HNHB LHIN initiated and participated in numerous activities and action plans rooted in respectful engagement, meaningful inclusion and harmonized partnerships with local Indigenous communities. The priorities and outcomes arising were further strengthened by the Ministry's commitment through *Patients First: Ontario's Action Plan for Health Care 2015*, to be more inclusive of Indigenous voices in system planning and service delivery to enable culturally appropriate care, incorporate traditional approaches with healing and wellness, and improve health care experiences.

Alongside and in partnership with local Indigenous partners, the LHIN continues to move forward towards improving the health and wellness of Indigenous populations by listening to stories from the community and allowing these experiences to shape current and future health programs and services.

Collaboration with the HNHB LHIN's Indigenous Health Network (IHN) and Six Nations of the Grand River Territory (SNGR) has contributed to stronger partnerships among local Indigenous providers and the LHIN. The IHN's connection and engagement with Indigenous community members across all LHIN sub-regions, brings forward the diverse perspectives and experiences of First Nations, Inuit, and Métis Peoples (FNIM) living both on reserve, off-reserve and in urban/rural settings. Collectively, the IHN strengthens the voice of Indigenous communities and provides essential advice and direction on local health care priorities, planning and service delivery. In April 2015, the IHN identified a new 2015-2018 Strategic Plan based on the health needs of local communities and the health-specific recommendations identified in the Truth and Reconciliation Commission of Canada's (TRC) Final Report and Calls to Action. The five key priorities identified were:

1. *Indigenous Cultural Competency*
2. *Access to Traditional Healing*
3. *Strengthening the Family Unit*
4. *Mental Health & Addictions and Suicide Prevention; and*
5. *Chronic Disease Management & Prevention*



To support these priorities, the IHN engaged in a variety of activities during 2016-17 including:

- In partnership with Fort Erie Native Friendship Centre (FENFC), Indigenous Diabetes Health Circle (formerly SOADI) and other IHN organizations, De dwa da dehs nye>s Aboriginal Health Centre (DAHC) led the development of a plan to broaden access to mental health services, patient navigation, primary care, and traditional healing in Niagara. Support for a Niagara-based adult mental health case manager and the enhancement and coordination of an outreach program model in Niagara was approved by the LHIN Board in December 2016. DAHC has since recruited a Niagara-based mental health case manager and implemented a central intake and scheduling process to increase access and reduce wait times for clients seeking mental health services.
- In November 2016 and March 2017, the IHN hosted two community engagement gatherings in Niagara and Brantford respectively, attended by approximately 220 individuals. These gatherings brought together Indigenous community members, Indigenous health and social service providers, and mainstream health care organizations to learn, share, and discuss current experiences, barriers, and opportunities to improve health care for Indigenous communities. Feedback from these two engagements included recommendations in the areas of cultural safety, Traditional medicine, mental health and addictions, diabetes, home and community care, and end-of-life (EOL) care. More information, including a final report from each event, will be compiled and made available on the HNHB LHIN website to inform and guide future planning.

- To support the effective implementation of the Health Links model across the HNHB LHIN, Indigenous organizations including DAHC, Indigenous Diabetes Health Circle (formerly SOADI), and three Friendship Centres were engaged and identified as care partners involved in developing coordinated care plans for Indigenous community members who would benefit from this approach to care.

Cultural Safety Training

Over the past year, the LHIN has continued to support increased and broadened access to Ontario's Indigenous Cultural Safety (ICS) training as an educational platform contributing to improved cultural safety across the health care system. In 2016-17, 316 individuals participated in ICS training which included staff from the LHIN as well as 50 different health care providers including hospitals, community health centres, family health teams, mental health and addictions providers, and home and community care.

Cultural safety training helps to mitigate the impacts of systemic racism by improving communication between health service providers and Indigenous patients and families. More specifically, Ontario's ICS training is founded in principles of respect, safety, and trust, offering an interactive environment for health professionals to expand their knowledge of Canada and Ontario's Indigenous Peoples, increase self-awareness of culture, and develop skills to work more effectively with Indigenous Peoples.

Traditional Healing

Between March and May 2016, the LHIN met with SNGR HSPs and physicians to identify key priority areas for improving access to care for SNGR residents. Consistent with the priorities of the IHN, SNGR Moving Forward Project and the Truth and Reconciliation Commission of Canada Final Report, these meetings further identified a need for increased access to Traditional medicine resources to advance the harmonization of Indigenous and mainstream approaches to care. In June 2016, SNGR received LHIN support for the Ogwanohgwatae:' (We Have Good Medicine) Traditional Medicine Program (OTMP). This support acknowledges the importance of incorporating Traditional medicine into the healing circle and supporting the sustainability of Traditional medicine and healing practice within SNGR and surrounding communities. During the first four months of operation, December 2016 through March 2017, the OTMP helped 128 individuals through 431 visits, which included a combination of one-on-one healing sessions and cultural ceremonies *(Source: 2016-17 Quarterly Supplemental Performance Reporting).* OTMP also initiated the first phase of a referral protocol under the guidance of SNGR Traditional Medicine Advisory Council, to build a pathway for individuals, families, and health care providers to access this service. Through ongoing outreach efforts and spreading word of mouth in the community, awareness and understanding of this program continues to grow rapidly.

Patient Navigation

Three Aboriginal Patient Navigators (APN) and two Aboriginal Child and Youth Mental Health Navigators continue to serve Indigenous clients across Hamilton, Niagara, Haldimand-Norfolk, Burlington, Brantford, SNGR and MNCFN. This role is intended to work with Indigenous and mainstream health and social service organizations, home and community care and hospitals across the LHIN to support Indigenous clients, caregivers and their families as they navigate the health care system. As a result of increased awareness campaigning and improved communications with mainstream organizations, community members and health care staff have become more familiar with how to contact the APN program. This program has seen a consistent quarter over quarter increase in the number of referrals and individuals served from April to December 2016, providing a total of 2,167 clients with access to culturally appropriate supports and services during this time period *(Source: 2016-17 Quarterly Supplemental Performance Reporting).*

Aboriginal Patient Navigators (APN) – Work with Indigenous clients and partners from health and other services to improve the client (family) experience

Louise has many complex medical conditions with frequent hospitalizations. While Louise was in hospital for several months, her partner, John, was feeling overwhelmed caring for Louise, their young child, and household. After Louise's discharge home, the APN arranged in-home services, however, the support staff refused care due to health and safety risks in the home. Already overwhelmed, John became Louise's primary caregiver. Children's Aid Services (CAS) was contacted due to the poor living conditions and family was required to make improvements. The APN was called again, as the family could not do this on their own. Within two days, the APN arranged a case conference with community providers to find a solution. Community members gathered to help clean the home, which addressed concerns raised by CAS. In-home services were reinstated and now John, Louise and their child remain one whole family.

Sub-region Planning with Indigenous Partners/Engaging Communities

In 2016-17, the HNHB LHIN met regularly with Indigenous partners to develop a plan for appropriate and equitable inclusion in sub-region planning. These discussions included three meetings with SNGR health care providers and physicians, four meetings with the IHN, bi-monthly updates at IHN business meetings, and SNGR representation at six LHIN-wide sub-region planning sessions. Based on the feedback provided, key considerations for sub-region planning included recognition of the diverse community health needs across each sub-region, the complexities of navigating Indigenous and mainstream health care services, and the need for planning decisions that reflect community-driven approaches to care. Indigenous partners also noted the strength and importance of planning together across all sub-regions to strengthen the voice of Indigenous communities, while also addressing capacity limitations among local agencies.

Francophone Health Engagement

The *French Language Services Act (FLSA), Ontario, 1986*, recognizes the contribution of the French speaking population to the historical, cultural, and linguistic heritage of Ontario. The *FLSA* guarantees the right of French speaking Ontarians to communicate with the government and receive services in French. Under the requirements of the *Local Health System Integration Act (LHSIA)*, the LHIN is responsible for ensuring that the French-speaking population has equitable access to a full range of health services in French. To this end, the LHIN funds, plans and promotes French Language Services (FLS), and engages the French speaking community in the process. French speaking residents and stakeholders know their communities best and the goal is to ensure the best outcomes for French language health services, acknowledging and respecting diversity within Francophone communities. The *Patient First Act, 2016*, recognizes the Francophone community as a priority population. The Ministry put in place a FLS work stream to clarify the roles, responsibilities and accountability around services in French from the perspectives of the Ministry, the LHIN, HSPs and the French Planning Language Entity (FLPE).

Partners in Health

In 2011, the Waterloo Wellington (WW) and HNHB LHINs, and the French Language Planning Entity (FLPE), signed a funding and accountability agreement which formed the basis of a partnership with the FLPE. In 2016-17, the LHINs and the FLPE developed a Joint Annual Action Plan (JAAP) which set out the objectives, priorities and actions for each parties. Based on the JAAP, the FLPE provided an annual work plan and a community engagement plan which had a particular focus on Francophone immigrants and diversity within the Francophone community across the HNHB LHIN. The FLPE released a portrait of the Francophone immigrants who account for more than 16.5% of the total Francophone population, with a large majority originating from French speaking countries in Africa. Francophone immigrants do not always settle in designated areas (such as Welland or Hamilton), but often in centers such as St. Catharines or Brantford, which are non-designated areas. The HNHB LHIN participated regularly on two Francophone interagency tables (Niagara Region and Hamilton) to share information and to contribute to collaborative projects in partnership with various stakeholders.

Francophone Community Engagement

In August 2016, the HNHB LHIN convened a meeting with FLS providers regarding the Patients First Strategy and FLS. Partners had an opportunity to discuss challenges and perspectives brought by the new legislation, and in particular, the sub-region planning. The three main areas raised were Governance and Strategic Direction, Access and Navigation and Support for Agencies. For each subject, the participants identified issues and opportunities regarding future perspectives including setting up goals and planning with agencies, and finding solutions to help with recruitment for bilingual staff.

The HNHB LHIN promoted the *Welcoming Communities Initiative*, a project led by the Réseau franco-santé du sud de l'Ontario , aimed at all HSPs. This community-support strategy aimed at recruiting, integrating and retaining bilingual health professionals in minority settings. The program facilitates linkages between colleges and universities and employers in the health system. In 2016-17, eight HSPs in our LHIN were registered and three students had a placement or internships.

The September 2016 *Voices in the Community* video, told the story of Siena Trigani, a francophone client receiving services through CNIB. This patient experience provided an example of how the Active Offer of French language health services is making a difference for people who need them. The Active Offer is

the clear and proactive offer of services in French to individuals, from the first point of contact, without placing the responsibility of requesting services in French on the individual. The video was unveiled during the September Board meeting, promoted in *LHINsight* and is available on the LHIN website.

Listening, Learning and Developing Services

The HNHB LHIN and the CCAC continued to work on an FLS compliance plan, set up a FLS committee and established a work plan. The LHIN and the CCAC completed a readiness assessment based on a foundational document and checklist for compliance with the FLSA. A combined readiness assessment pointed out gaps and opportunities for the new LHIN organization to become the basis of the work plan to address priority gaps. The next steps will be to develop and implement a FLS plan that meets the requirement that the HNHB LHIN plan, fund, integrate and deliver local health services for the Francophone community in accordance with the FLSA.

Recruiting bilingual health professionals is a key component of the effective provision of services in French. Health service providers are challenged by a shortage of bilingual professionals and therefore experience difficulty in building capacity in French. A lack of information in the education system about opportunities in health care has been identified as contributing to gaps in the recruitment of bilingual professionals. On March 20, 2017, the health sub-committee of the Niagara Interagency table (comprised of the Réseau franco-santé du sud de l'Ontario, the FLPE, the HNHB LHIN, the Centre de Santé, Alzheimer Society, Brain Injury re-entry Niagara and the Foyer Richelieu), piloted an initiative called the Health Career Bus. The intent of this initiative was to increase awareness, among young French speaking students, of the career opportunities available to them in Niagara Region in the fields of nursing, psychology and gerontology. Twenty-five students visited five HSPs resulting in at least one successful recruitment, and an increased level of awareness of local opportunities.

Physician Engagement

The HNHB LHIN recognizes that physician engagement is a critical component in the planning and implementation strategies to ensure equitable access across our entire LHIN. Working closely with physicians is imperative to our continued success.

In 2016-17 the HNHB LHIN focused on preparing for the Patient First Act and established six sub-regions (geographic areas within a LHIN to enable health planners and providers to better identify and respond to the health care needs of local communities), which will enable the LHIN to continue building primary care as the foundation of the health care system.

Primary Care

Sub-region engagement sessions were held in each of the six sub-regions along with primary care 'conversations' with formal and informal leaders to learn about the opportunities and strengths to build upon within each sub-region. The 'conversations' with primary care providers identified the following priorities:

- Improve patients' access and attachment to primary care;
- Improve patients' access to inter-professional health care;
- Integrate the Health Links model of care into sub-region planning;
- Improve patients' timely access to specialists; and
- Embed care coordinators/system navigators in primary care to ensure smooth transitions of care between home and community care and other health and social services

Technology

As one of the largest geographic LHINs in Ontario, the use of technology to improve access to specialists and reduce travelling for patients and their caregivers is essential.

- The HNHB LHIN has been working with Ontario Telemedicine Network (OTN) and OntarioMD to implement eConsult, which enables doctors to consult with specialists over a secure video network without the patient travelling to visit the specialist. A variety of communication methods have been used to ensure all physicians within the HNHB LHIN are aware of this opportunity. We continue to work with OTN and OntarioMD to facilitate the registration and education.
- Personal computer videoconferencing (PCVC) is a tool which enables a physician in one location to connect over a secure device (for example, a laptop) to a patient in a different location to support their care. PCVC is currently being used for mental health and addictions services. Following a very successful demonstration of the use of PCVC in emergency rooms for patients with mental health conditions to Chiefs of Psychiatry and the clinical administrators of various HNHB LHIN hospital sites in January 2017, there was considerable interest in the use of technology.
- Central intake will enable the LHIN to have a single referral point and streamline referrals for specific conditions such as joint replacements, computed tomography (CT) and magnetic resonance imaging (MRI) with real time status updates to ensure equity and standardization of care for patients.
- The HNHB LHIN continues to have a variety of active physician networks and various ad hoc specialist and family physician groups. For example, the Diagnostic Imaging Steering Committee, made up of radiologists and their administrative colleagues, has worked on improving standardization across the LHIN. This past year, common CT and MRI referral forms were created which included a standardized, best-practice use of contrast. These common referral forms will facilitate the development of a central intake process and also will incorporate many of the *Choosing Wisely Canada (CWC)* guidelines.
- The Regional Vision Steering Committee continued to focus on patient access to specialist care for various vision diseases as well as working with primary care and emergency room physicians on the education of specific eye diseases. Over the past year, this Steering Committee has begun to better understand the population health needs for vision care in each of our sub-regions.

Our Strategic Health System Plan – Dramatically improving the patient experience through Quality, Integration and Value

In 2012, the HNHB LHIN undertook a strategic planning process to identify those key directions which, when implemented together, would transform the health care system for patients at the local level. The strategic directions, goals and deliverables stemming from the Strategic Health System Plan (SHSP) have guided the work of the HNHB LHIN over the past five years. The SHSP set out the overall aim of the HNHB LHIN to dramatically improve the patient experience through quality, integration and value through three key strategic directions:

1. *Dramatically improving patient experience by embedding a culture of quality throughout the system.*
2. *Dramatically improving the patient experience by integrating service delivery.*
3. *Dramatically improving the patient experience by evolving the role of the LHIN to become health system commissioners.*

In advance of the 2015-16 fiscal year and in anticipation of the Patients First renewal to come, the LHIN undertook a 'refresh' of its SHSP to re-confirm the strategic aim and strategic directions. Additionally, the refresh process identified the importance of a strong, engaged primary care sector, and a strong home and community care sector, integrated into the continuum of services focused on meeting the needs of the person.

System Integration – Patients First

Released by the Minister of Health and Long-Term Care (Minister) in February 2015, *Patients First: Action Plan for Health Care* represented the next phase of Ontario's plan to transform Ontario's health care system. It was built on a strong foundation set by Ontario's original *Action Plan for Health Care* released in 2012 and strengthened the government's commitment to put patients first by improving their health care experience.

On December 7, 2016, the Ontario government passed the *Patients First Act, 2016* – legislation that will help patients and their families obtain better access to a more local and integrated health care system, improving the patient experience and delivering higher-quality care. This legislation follows the 2015 release of *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* and represents the next step in the government's plan to deliver on the commitments made in the *Patients First: Action Plan for Health Care*. The *Patients First Act* reinforces the government's focus on integrating service delivery and will help ensure patients are at the centre of the health care system. Ontario's LHINs will be responsible for home care and primary care planning to ensure that patients are getting better coordinated care, and that the health system is more integrated and responsive to local needs.

System-wide Quality Improvement

Dramatically improving the patient experience through embedding a culture of quality throughout the system continues across the HNHB LHIN. The LHIN, its health service providers, and its partners are actively engaged in quality improvement efforts within individual services and programs, as well as across the health care system. A culture of always seeking opportunities to enhance the care experience, health outcomes and system performance has been fostered within the HNHB LHIN and examples of these initiatives are provided throughout this annual report.

The Regional Quality Table (RQT), formerly the Quality Guidance Council, continues to inform the LHIN's quality agenda, to support communication, and members act as ambassadors within the various sectors. The RQT expands on the current work of the LHIN with a focus on a culture of quality, quality obligations, patient experience and a cross-sector approach strengthened by the inclusion of the home and community services sector. By aligning the quality agenda and engaging communities, the ultimate goal is to create and promote a culture of quality that will enable improved patient outcomes and experience of care.

Quality Obligations

For the fourth year, all HSPs developed and submitted quality plans to the HNHB LHIN outlining their goals and initiatives to improve health outcomes and the care experience for patients, clients, and residents. The review of such quality plans has evolved over the years with a particular focus on further understanding the quality plans of HSPs in the community sector, those who are not obligated to submit a quality plan to Health Quality Ontario (HQO). The quality plans were reviewed by LHIN staff and common themes were identified. The reviews showed HSPs continue to have clear quality plans with identified improvement initiatives and measures. As a result, this continues to give us confidence that creating and sustaining a culture of quality improvement is top of mind with our HSPs, which is very encouraging. HQO continues to support Quality Improvement Plan (QIP) development by now providing LHIN snapshots of QIPs submitted directly to them. From the 2016/17 snapshot report, HNHB organizations self-identified making progress on the following integration indicators (as compared to across the province):

- 50% of HNHB organizations made progress on "Readmissions within 30 days for select conditions" as compared to 49% who made progress across the province.
- 41% of HNHB organizations made progress on "Timely access to a primary care provider" as compared to 40% who made progress across the province.
- 43% of HNHB organizations made progress on "7-Day Post-Hospital Discharge Follow-Up Rate for Selected Conditions" as compared to 28% who made progress across the province.
- 64% of HNHB organizations made progress on "Hospital Readmission Rate for Primary Care Patient Population" as compared to 37% who made progress across the province.

In previous years, the HNHB LHIN requested that HSPs submit a board-approved policy on quality and a balanced scorecard of key performance indicators. This requirement was removed in 2016-17 as we are confident our HSPs have effectively established these enablers. It is reassuring to know improving quality for our patients, residents, and clients is a priority across our sectors for our providers.

Moving forward, as we focus on sub-regions, the HNHB LHIN will continue to engage HSPs with respect to their quality plans as we look to ensure the residents of our community receive care that is accessible, integrated, consistent, high quality, and of course, making a difference.

Patient Experience

Creating a positive health care experience for patients, residents and clients is of critical importance to the HNHB LHIN and its providers. An individual's perception of their health experience is influenced by all aspects of care and service. Building on the patient experience framework developed in 2014-15, the HNHB LHIN included an obligation in all Service Accountability Agreement Local Obligation Schedules. The obligation requires providers to collect and report information regarding two aspects of patient experience: overall satisfaction with the care and services received and involvement in care decisions. This creates a shared focus on patient experience and establishes baseline data across the LHIN.

185 HSPs submitted a Patient Experience Indicator Survey for 2015-16. The average percent of respondents who responded favourably to the question regarding overall satisfaction was 88.5%. The average percent of respondents who responded favourably to the question regarding involvement in decisions about care was 84.8%.

Performance Management

The HNHB LHIN's Performance Accountability Policy outlines principles to guide performance management and sets out a clear relationship between the LHIN and HSPs, the role of governance in performance improvement and identifies the steps to address performance challenges.

The Policy helps answer key questions related to effectiveness, efficiency and quality:

- Are health service providers delivering what they're supposed to be delivering? (Effectiveness)
- Are health service providers delivering services as efficiently as possible? (Efficiency)
- Are there some things that other health service providers can do better? (Quality)

Performance management is crucial to ensuring quality health care services and programs are available for people when they need them. Recognizing the importance of monitoring service delivery volumes, efficiency, and resource stewardship, the LHIN continued its efforts to refine practices to support a robust performance management system. In March 2016, the LHIN engaged with six out of nine hospitals to request a brief report or "Performance Indicator Action Plan" (PIAP) for select indicators, as per the Hospital Service Accountability Agreement (HSAA).A total of seven performance indicators, across six hospitals, were selected for the PIAPs, and five of the performance indicators were HNHB LHIN priority indicators. The most frequently requested indicators were *ED Length of Stay for Complex Patients*, *Percent ALC Days* and *ALC Rate*. The LHIN engages with the hospitals quarterly for PIAP updates, and summaries are provided to the Board.

For 2015-18, the Ministry-LHIN Accountability Agreement (MLAA) includes 14 local health system performance indicators, eight monitoring indicators and two developmental indicators. These indicators form the core metrics for performance management within the LHIN, and focus on home and community care, system integration and access, health and wellness of Ontarians, and sustainability and quality. In February 2017, updated MLAA data on local health system performance indicators was released to the LHIN. The LHIN will continue to closely monitor these indicators as proxies for system performance,

working with providers on LHIN-wide improvement strategies, and reporting on progress towards targets to the Board on a quarterly basis.

Enterprise Risk Management

The LHIN uses an Enterprise Risk Management (ERM) approach to identify, assess, mitigate and communicate key risks in the LHIN. Key elements of ERM include:

- Health service provider and LHIN Strategic, operational, financial and reputational risks will be monitored and it is the responsibility of staff at all levels of the LHIN to identify risk;
- LHIN staff will consult with LHIN leadership to determine whether a risk will be elevated to the Ministry;
- Risks will be brought forward to leadership on a regular basis; and,
- Each risk will be updated until the risk is mitigated through risk management plans.

The number and complexity of HSPs in the LHIN requires prioritization based on identified risks. On a quarterly basis the LHIN utilizes a methodology to rank agency risk on a quarterly basis to assess compliance with service accountability agreements, key performance indicators, data quality, and core financial indicators.

The LHIN regularly reports risks to the Board's Quality and Safety Committee and the Ministry. Monitoring organizational risk is one of the ways LHINs work to ensure value for money, access to services and access to the best patient care for people and their families. Achievement of the Performance Indicators within the Ministry LHIN Accountability Agreement has been identified as an area of high risk by the LHIN. Below are strategies we are undertaking to mitigate the risk:

- Assigned provincial targets within HSP SAAs to create alignment and focus throughout the LHIN;
- Monitor current results on performance indicators on a regular basis and report quarterly to the LHIN Board of Directors;
- Review performance results with HSPs on a quarterly basis and also relevant LHIN-wide steering committees responsible for overseeing practice related to particular clinical programs and services; and
- HSPs are obligated as per their 2016-17 accountability agreement to participate in activities and initiatives to improve performance and demonstrate an improving trend towards target on these key performance indicators.

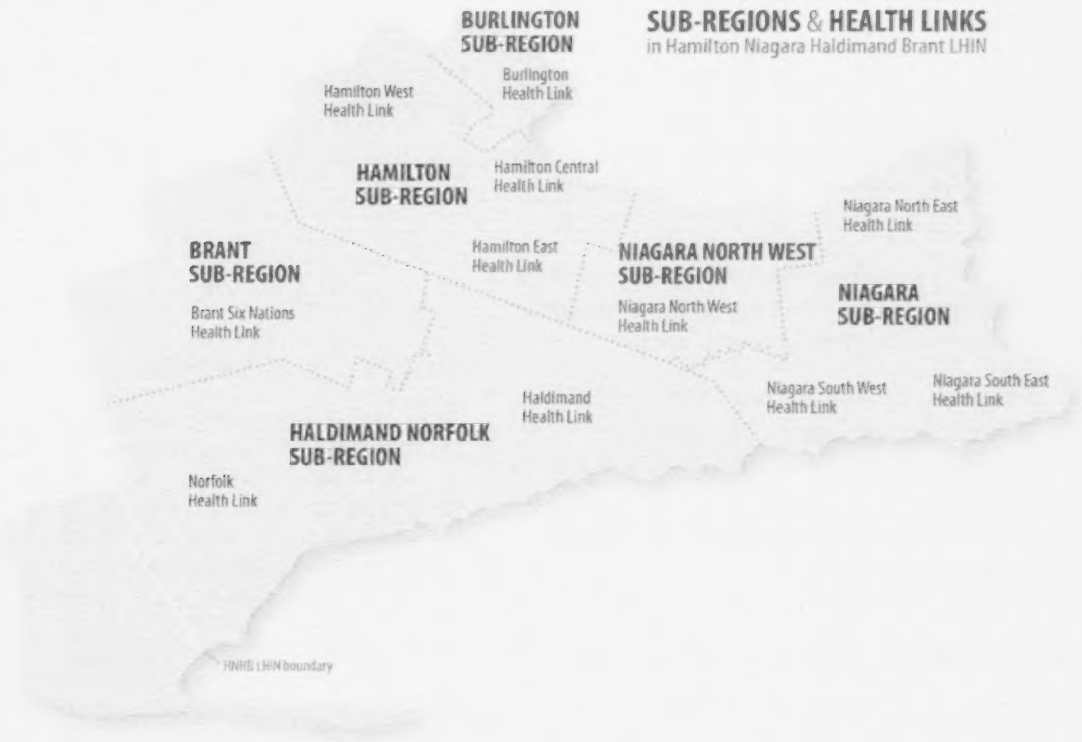
Integration – Health Links as a Model of Integrated Care Delivery

Improving the patient experience by integrating service delivery begins at the local level - integrating care delivery for a group of individuals - one person at a time. Integrated service delivery means the system will focus on patient-centered care including supporting the Health Link model of care.

Health Links were introduced as a key commitment in the MOHLTC's 2012 Action Plan for Health Care with a goal to transform the system through increasing access to integrated, quality services for Ontario's patient population living with complex chronic conditions and the ministry continues to support the important work of Health Links. The care coordination, service delivery and integration activities that are central to the Health Links model are foundational to the Patents First strategy.

Health Links provided the starting point for the HNHB LHIN's sub-region geographic area analysis (see Figure 3), and will be foundational to support the further integration of services at the community level. Health Links has been a good example of how LHIN funded and non-funded providers are working together to provide care for this sub-population in the HNHB LHIN.

Figure 4 – HNHB Health Links and Sub-region Map



HSPs across the HNHB LHIN have continued to scale and spread the Health Links model of care with a focus on:

- Working with patients on their goals and associated actions;
- Supporting patients in their health care journey and focusing on an improved quality of life;
- Having more consistent understanding of their patient's conditions and what matters to them; and
- Supporting care across the transition points between service providers, from acute to community.

HSPs continue to establish mechanisms to identify in real-time time those patients who would benefit from a coordinated care plan developed using the Health Links model of care. In 2016-17, HSPs completed more than 1,300 coordinated care plans for patients living with complex chronic conditions. These care plans adopt best practices related to person-centred care planning.

The HNHB LHIN has been tracking the outcomes for those patients with a coordinated care plan and has seen a statistically significant reduction in Emergency Department visits, hospitalizations, readmissions and days spent in hospital when comparing 12 months pre and post care plan.

The HNHB LHIN completed a patient experience survey in winter 2015-16 with the final analysis being completed in early 2017-18 and for those that responded:

- 89% knew who was on their health care team
- 89% felt that they had been listened to
- 89% were involved in making decisions about their care
- 88% always had their questions and concerns addressed
- 83% said that their experience had improved

Participants identified the following successes in their response:

- Health Links helped aid in easing worries and reducing wait times;
- Better quality of life associated with more efficient care;
- Many clients and caregivers mentioned being well involved in their care plan;
- Social situation was addressed through Health Links;
- Health care teams worked with them to try alternative methods; and
- Respect for individual preferences.

Observed Results Among Patients with a Coordinated Care Plan

- 26% reduction in Emergency Department visits
- 40% reduction in hospital admissions
- 32% reduction in days spent in the hospital
- 39% reduction in hospitalization for ambulatory care sensitive conditions
- 44% reduction in 30 day readmissions

Alex's Story

Alex is a 41-year-old Burlington resident living with numerous complex chronic and mental health conditions, significant social needs and no family available to provide support. In the 12 months prior to becoming involved with Health Links, Alex had 51 ED visits and was admitted to hospital on 7 occasions. A Care Coordinator, working closely with primary care providers, hospital staff and home and community care workers, focused on what mattered most to Alex – building trusting relationships, enhanced communication and developing an action-based care plan that addressed specific needs and goals and improved the patient experience. In the year since the care plan was implemented, Alex has been to the ER only 19 times and has had no hospital admissions.

Clinical Program Integration

The HNHB LHIN is home to a sophisticated network of hospital-based programs and services, providing a full range of secondary and tertiary specialized services to residents of our LHIN and beyond. LHIN-wide integrated clinical programs provide specialized services, based on the key concept of 'one clinical program – multiple sites'. The goal of LHIN-wide clinical programs is to ensure that all residents across the LHIN have access to a coordinated program, following the same care delivery and quality standards, regardless of where they live.

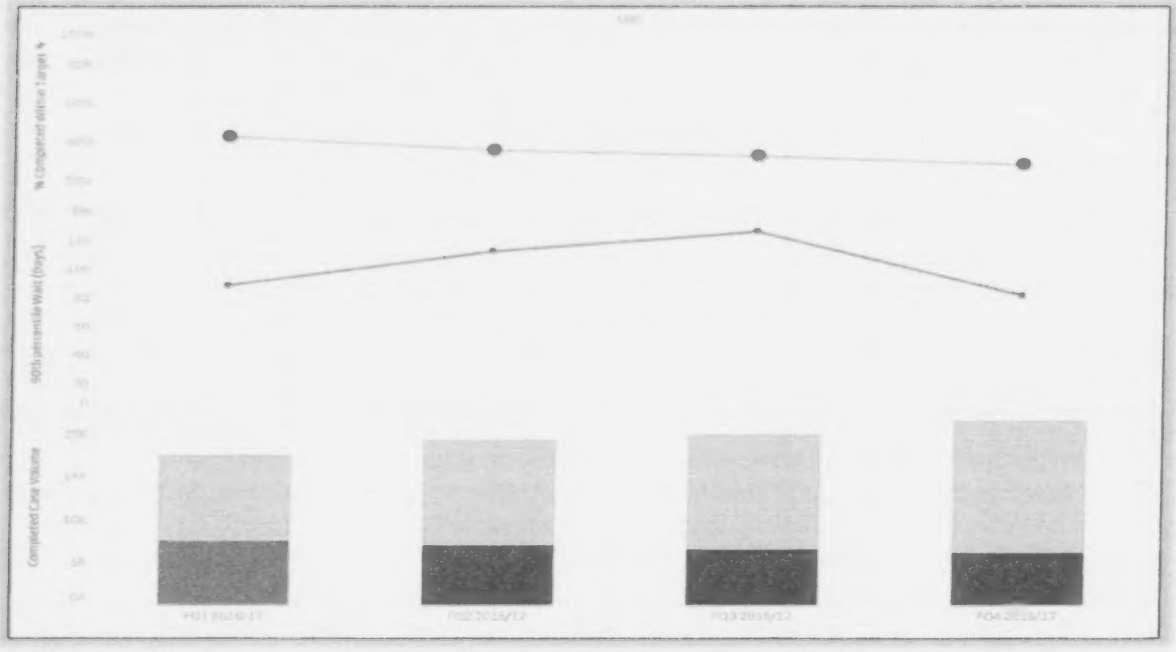
Diagnostic Imaging

Targets for diagnostic treatment are established provincially, with Priority 4 (elective) patients referring to a wait time of 28 days or less. In 2016-17, 66,378 Priority 4 MRI scans and 40,052 Priority 4 CT scans were completed within the LHIN *(Source: Adult Diagnostic Imaging Wait Times Report (Access to Care, Cancer Care Ontario))*. These are significant numbers and reflect the growing demand and increasing complexity of diagnostic tests, factors which continue to contribute to ongoing challenges in providing timely access to diagnostic services.

In the fourth quarter of 2016-17, 28% of combined (P2-4) MRI scans and 71% of CT scans were completed within the clinical wait time targets. Due to volumes and capacity, MRI performance was significantly below the provincial target (90%) and below the provincial average (42%). New investments for MRI in October 2016 resulted in an increase in the number of MRI cases complete.

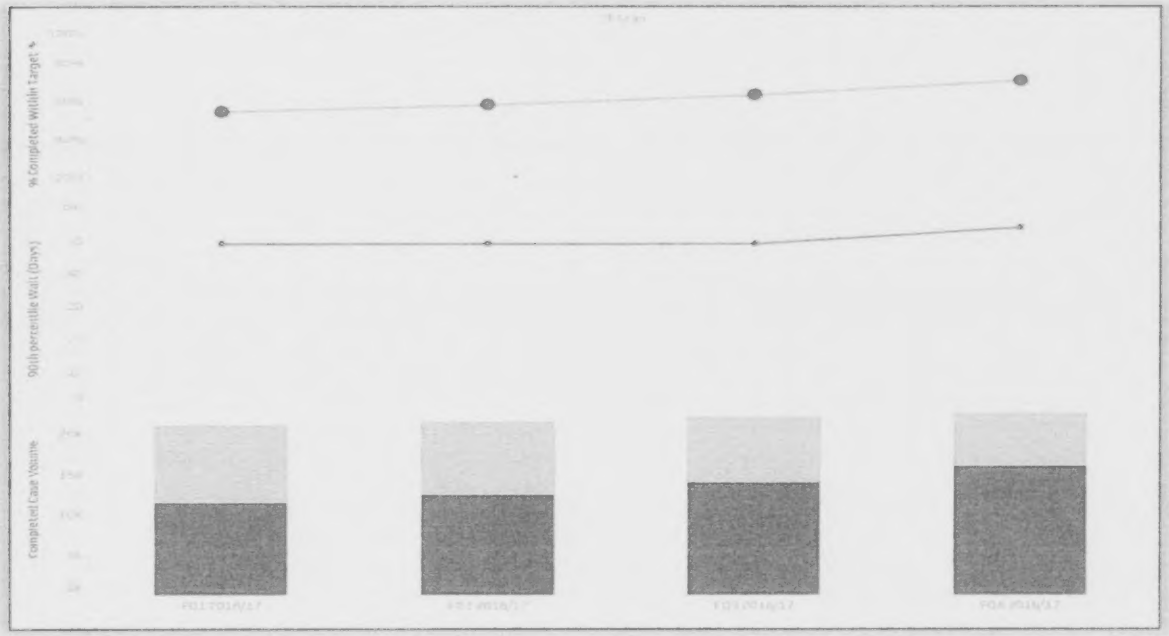
(Source: Provincial Priority Procedures Report (Access to Care, Cancer Care Ontario)).

Figure 5: MRI - % Completed Within Target, 90th Percentile Wait (Days), & Completed Case Volumes



CT performance was also below the provincial target (90%), and below the provincial average (79%). The LHIN and its providers have much work to do and the LHIN will continue to work with hospitals to support the prioritization of patients with the most medically urgent diagnostic imagining needs.

Figure 6: CT Scan - % Completed Within Target, 90th Percentile Wait (Days), & Completed Case Volume



The Diagnostic Imaging Steering Committee and the Diagnostic Imaging Directors Working Group continue to align and integrate administrative and clinical practices for DI services across the HNHB LHIN hospitals. Committee achievements in 2016-17 that improve the health care system by incorporating efficiency, effectiveness and appropriateness into the delivery of diagnostic services include:

- Formalizing and strengthening the DI Steering Committee to include representation of both administrative and physician to ensure alignment of priorities and enable sharing of best-practices and efficient decision-making.
- Collaborating with Cancer Care Ontario (CCO) Access to Care staff to develop an MRI allocation tool to assist in optimizing resources across the LHIN and achieving MLAA targets. The tool has been shared with LHIN hospitals to explore how it can be used at the hospital level.
- Continued support of the Choosing Wisely Canada (CWC) initiative by implementing the five recommendations to prevent unnecessary diagnostic imaging testing. In addition, at the recommendation of the QBP Handbook for Primary Hip and Knee Replacement, the DI Steering Committee mandated that plain film results be provided with MRI knee referrals for suspected osteoarthritis in an effort to reduce unnecessary demand for MRI. The DI Steering Committee continues to monitor best practices that improve the appropriateness of diagnostic tests.
- Development of a standardized form for MRI and CT referrals that includes LHIN best practice as to the use of contrast. The implementation of common referrals forms will assist in improving the quality of service and communication for diagnostic imaging services by standardizing the

way information is sent and received. This is a first step in the LHIN's long-term goal to develop and implement centralized and coordinated access for CT and MRI referrals which will reduce duplication of efforts, increase efficiency and ensure patients receive the most appropriate service by the most appropriate provider.

- Making wait time information publicly available in order to improve transparency and referral patterns and reduce variation across the HNHB LHIN. The public availability of wait time information empowers patients to make informed decisions about their health and health care, to ask their family physician about the waiting list and to determine feasibility to access services quicker by accepting a referral to another hospital with a shorter wait. It also, empowers health service providers to discuss health care options with patients, find a hospital with the shortest wait time, and to consider the appropriateness of the examinations and potential alternatives. This initiative will complement the implementation of common referrals forms to improve referral patterns, and reduce the variation of wait times.

Orthopedics

Orthopedic treatments encompass a wide variety of injuries and disorders to the skeleton and supporting muscles, collectively known as the musculoskeletal (MSK) system *(Source: Canadian Orthopaedic Foundation. 2016. Accessed from: http://whenithurtstomove.org/).* The range of orthopedic care provided within the HNHB LHIN is comprehensive, ranging from basic assessment and treatment of minor injuries, to the provision of specialty, tertiary and quaternary orthopedic trauma and oncology care. This includes the medical management of patients who have orthopedic ailments, but for whom surgery is not an option.

A large number of orthopedic injuries and disorders involve joints. Joint pain can have a profound impact on a person's quality of life and when required, total joint replacements are a cost-effective treatment, particularly for those patients with advanced arthritis, and those experiencing constant pain and/or a loss of mobility *(Sources: MOHTLC, Quality-Based Procedures Clinical Handbook for Primary Unilateral Hip Replacement. June 2012; MOHLTC. Quality-Based Procedures Clinical Handbook for Primary Unilateral Knee Replacement. June 2012).*

Since its establishment in 2014, the focus of the HNHB LHIN Orthopedic Leadership Steering Committee has been primarily on total hip and knee replacement surgery and acute hip fracture care.

In 2016-17, 1,881 hip replacement and 3,080 knee replacement Priority 2, 3 and 4 (P2-4) surgeries were completed in HNHB LHIN which represents 11% of the province's volumes. This represents an over 3% increase in total HNHB LHIN hip and knee volumes from 2015-16 (an additional 135 hip and 55 knee replacement procedures in 2016-17) reflecting the growing demand, which continues to contribute to ongoing challenges in providing timely access to hip and knee replacement surgery.

While the HNHB LHIN has not yet met the provincial wait time targets for either total hip or knee replacements, wait times have improved since the introduction of the Ontario Wait Time Strategy. The HNHB LHIN has seen wait time decreases of 32% for knees and 38% for hips since 2006 *(Source: iPort Access to Care – Accessed February 21, 2017).* In 2016-17, 74% and 66% of P2-4 hip and knee replacement surgery cases, respectively, were completed within the 182 day access target. However, the LHIN's performance was below the provincial target (90%) and the provincial averages (78% and 75%, respectively) due to volumes and capacity (Figures 7, and 8) *(Source: Provincial Priority Procedures*

Report (Access to Care, Cancer Care Ontario)). The LHIN will continue to work with the hospitals to monitor performance and to develop solutions to improve access.

Figure 7: Hip - % Completed Within Target, 90th Percentile Wait (Days), & Completed Case Volumes

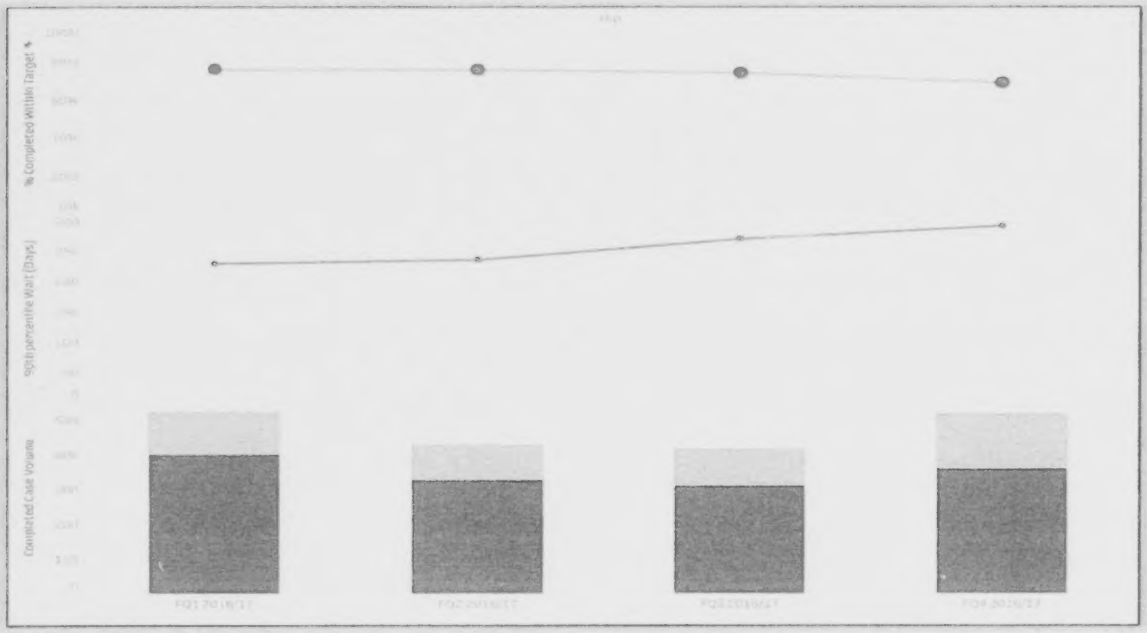
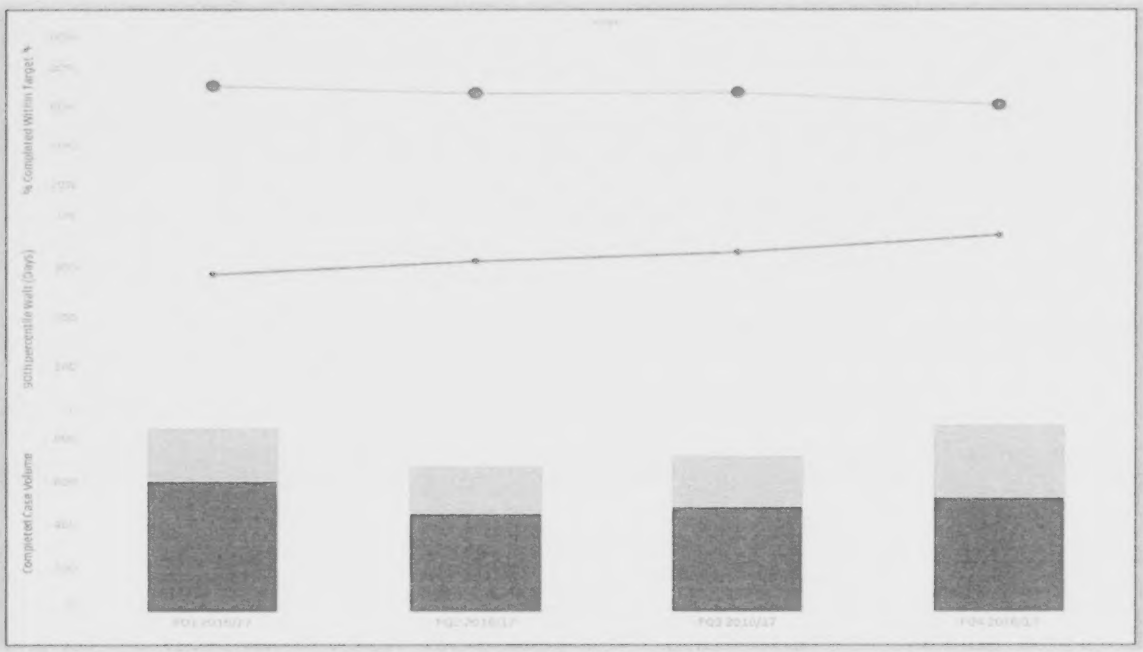


Figure 8: Knee - % Completed Within Target, 90th Percentile Wait (Days), & Completed Case Volumes



The HNHB LHIN has implemented collaborative partnerships with hospitals to improve wait times and promote standardization across the LHIN for patients requiring total joint replacement. Specific emphasis has been placed on wait list management, accurate data reporting, and referral redirection to first available surgeon through the Regional Joint Assessment Program.

The HNHB LHIN Orthopedic Leadership Steering Committee continues to develop and implement LHIN-wide improvement strategies, with a particular focus on continuing to improve wait times and increasing the equity of access to total hip and knee replacement as well as acute hip fracture surgeries across the LHIN's sub-regions. In 2016-17, the following LHIN-wide initiatives were achieved or launched:

- Wait time information was made publicly available to enhance patient and referring provider decision-making about where to seek orthopedic care.
- In partnership with primary care providers, implementation of the *Choosing Wisely Canada* recommendations for reducing the unnecessary use of MRI and C scans for the diagnosis of suspected osteoarthritis.
- Developed standard plain film requirements/views for the workup of potential total joint replacement (TJR).
- A Regional Joint Assessment Program (RJAP) First Available and Appropriate Surgeon Referral Policy/Process was developed and scheduled to be implemented by March 31, 2017. This policy/process will improve access to timely surgery by standardizing the offer of a first available and appropriate surgeon to patients requiring TJR
- Development of an RJAP Patient No Show Policy which both outlines a policy for patients who cancel two consecutive appointments and also facilitates the redistribution of cancelled clinic appointments to other patients waiting (currently under development).
- Formalization of a bi-annual RJAP patient experience survey and site-specific improvement plans based on the survey results. Also, in order to gather more detailed information to inform the improvement plans, a follow up to the bi-annual RJAP patient experience survey was conducted via a short telephone survey with a small sample of patients across the LHIN in late 2016. A significant proportion of the survey responses indicated high satisfaction with the RJAP experience. The results also demonstrated increasing levels of patient satisfaction since the last survey.
- Evaluation of the effectiveness of the Hip Fracture Partnership established between small and large hospitals in 2015. The partnership was a structure for the repatriation of patients to 'home' hospital sites following surgery, and decreased length of stay and it was found that the partnership had its intended effect.
- Utilization of processes detailed in the LHIN - Hospital Service Accountability Agreement (HSAA) to request hospitals to identify performance plans for specific indicators. This included plans to address surgeons reporting wait times substantially higher than the provincial target.
- A 7.6% increase in the volume of patients seen through RJAP in Niagara Region with additional resource at NHS St. Catharines site.

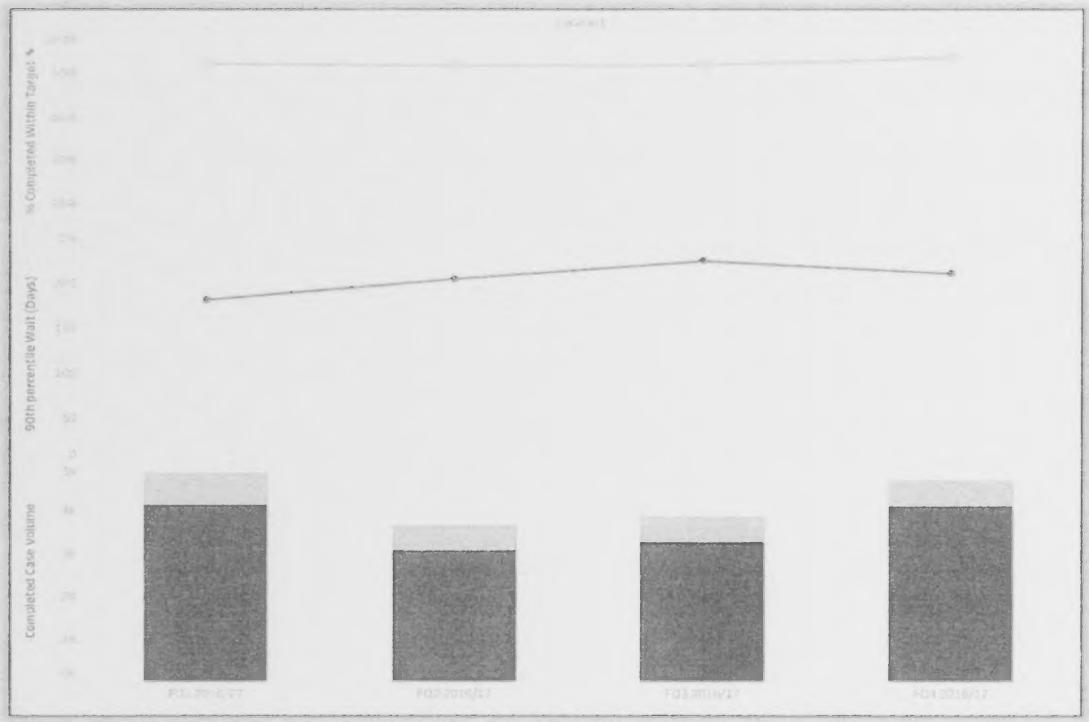
Ophthalmology

Ophthalmic care within the HNHB LHIN is anchored within five hospital sites across the HNHB LHIN: St. Joseph's Healthcare Hamilton (SJHH), Joseph Brant Hospital (JBH), the Niagara Health System (NHS), Brant Community Healthcare System (BCHS) and Norfolk General Hospital (NGH).

While the bulk of ophthalmic adult day surgery interventions consist of cataract treatments, a significant amount of clinical activity is also directed to other ophthalmic procedures. In 2016-17, other than cataracts, the most frequently performed procedures included: surgical and medical retinal treatments, glaucoma surgery, corneal procedures, and strabismus correction.

Ophthalmic performance is primarily measured through wait time targets related to the treatment of unilateral/routine cataracts. In 2016-17, the LHIN achieved performance targets for Priority 2 – 4 cataract patients in approximately 84% of cases. In 2016-17, the ability to meet provincial cataract wait time targets varied significantly by site. SJHH, NHS, and BCHS consistently met or outperformed provincial wait time targets across all priority levels *(Source: Provincial Priority Procedures Report (Access to Care, Cancer Care Ontario)).*

Figure 9: Cataract - % Completed Within Target, 90th Percentile Wait (Days), & Completed Case Volumes



Leadership and oversight for the ophthalmic priorities is provided by the HNHB LHIN Vision Steering Committee, which consists of surgical and administrative leaders from each of the LHIN's five hospital sites – SJHH, JBH, NHS, BCHS and NGH. In 2016-17, the Steering Committee championed a number of priorities to improve the delivery of ophthalmic services within the LHIN, including:

- Transparent sharing of cataract surgeon wait times through hospital websites was sustained to improve the ability of all physicians and eye care professionals to refer to the ophthalmologist with the lowest wait time, and for patients to be fully aware of where timely access to cataract surgeons can be achieved.
- A mobile tele-ophthalmology screening program for patients with diabetes who were not receiving annual screening for diabetic retinopathy was sustained, improved and enhanced to include glaucoma screening.

In 2016-17, the Steering Committee developed four strategic priorities to guide work over the next three years including initiatives to improve:

- The patient experience, and further embed a culture of 'outcome-based' ophthalmology;
- Integration of emergency ophthalmic care;
- Patient access to ophthalmic care; and
- Examine additional measures to improve system coordination.

Laboratory Services

The HNHB LHIN Laboratory Medicine Network and Council clinically integrated into a regional laboratory system that provides consistent and standardized quality and care across all hospital laboratory sites called CoLabs.

The Co-Labs laboratory medical directors collectively developed the following recommendations related to laboratory testing utilization to ensure patients receive the most appropriate care:

- Standardized critical value test results and reporting have been sustained across the LHIN, ensuring patient's care consistency.
- Quality improvement initiatives to reduce patient test turnaround times have continued, and quarterly reviews are used to identify potential quality issues for patient-centered care.
- Transfusion medicine planning was implemented.
- Laboratory automation continues to enhance workflow efficiencies and test turnaround times, impacting the speed of access to the most appropriate care for patients.
- Strategic planning was initiated for laboratory medicine services.
- Choosing Wisely Canada recommendations continue to be implemented across sites, reducing unnecessary testing for patients and reducing risks.

Health System Commissioners

A key strategic priority for the LHIN is to ensure accessible, patient-centered services that reflect value for money. The LHIN maintains 188 SAAs with HSPs and monitors fiscal and operational performance. The LHIN is also responsible for working with individual providers on key system-wide priorities, including Mental Health and Addictions, emergency department (ED) wait lists, ALC, and supporting home and community care.

To drive a greater focus on value, the LHIN adopted commissioning best-practices - a proven international best practice in health care management. Commissioning is a complex process with responsibilities ranging from assessing population needs and prioritizing health outcomes to procuring products and services and funding bundles of services. As health system commissioners, the LHIN staff and Board continued to enhance health system decisions based on evidence and performance.

A key strategic component in the advancement of the LHIN's role in commissioning is provider engagement. The LHIN developed and implemented an engagement plan aligned with SAA negotiation timelines to ensure significant performance issues are addressed at the time of agreement negotiations.

Figure 10 – HNHB LHIN Commissioning Model:

Successes in Commissioning

In December 2014/January 2015 and in accordance with Ministry Guidelines for Collaborative Home and Community-based Care Coordination, the LHIN began the process of transitioning CCAC clients with low to moderate in-home personal support care needs to Community Support Service (CSS) agencies able to provide the same level of care. In order to maintain the current service levels, it was important the

hourly rate for services provided by the CSS agencies not exceed the average existing personal support worker (PSW) rate funded by CCAC.

LHIN-funded Assisted Living/Supportive Housing (AL/SH) CSS agencies that had been contracted to provide personal support services were invited to be a part of this new strategy. Seven of thirteen service providers indicated interest in providing Personal Support Services (PSS) at the LHIN-funded rate. Each of these providers was experienced in delivering outreach/in-home personal support services and had the required capacity for data monitoring and human resources. Once the interested providers were identified, providers came together to determine which areas of the LHIN they were able to service. The CCAC provided a list of clients who would be transitioned and providers were assigned hours and clients based on a client's location.

Since the initial transition of clients, additional clients have been added to service with the CSS agencies from the CCAC waitlist, including a bulk transition in 2015-16 and the implementation of an ongoing waitlist management strategy which was operationalized in December 2016.

Future Opportunities

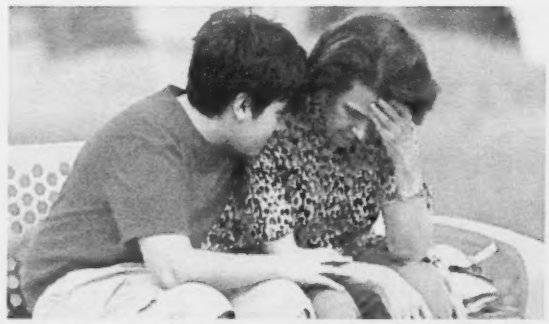
Over the last year, a number of commissioning opportunities have been identified in collaboration with HSPs, including:

- Leveraging funding opportunities to further enhance the LHIN health care system based on population needs and priority health outcomes;
- Further developing and evolving the use of frameworks and tools to assist in planning, allocating, monitoring and responding;
- Maximizing Health System Funding Reform (HSFR) to benefit HNHB residents – fully utilizing Quality Based Procedure (QBP) volumes and funding to HSPs; and,
- Continuing to support Mohawk Shared Services to integrate administrative support services in hospitals and develop a plan for reducing duplication in administrative support services in the community.

In 2017-18, the HNHB LHIN will further develop its role as health system commissioners focusing on quality, volume, price, enterprise risk management and accountability. The creation of sub-regions provides new opportunities for the LHIN to apply the tenets of commissioning at a more local level while ensuring alignment with government priorities and objectives. Outcome-based performance will be improved by working with the health sector to enhance existing and develop new quality frameworks that are consistent and flexible to address sub-region key priorities. As sub-region planning continues, the HNHB LHIN will explore population health needs, and prioritize funding to support the availability of and access to programs and services that support the best possible outcomes.

Advancing Health System Priorities

Mental Health and Addictions



In Ontario, the Mental Health and Addictions (MHA) system is characterized by a multitude of service and support providers, agencies and levels of government accountability, and funding sources. The complexity of the system presents a challenge for persons needing access to MHA services, their families, primary care providers and HSPs supporting the person.

The HNHB LHIN funds 38 HSPs to specifically provide MHA services. There are also numerous other LHIN and non-LHIN funded HSP/agencies/organizations that provide support to persons with mental illness and/or addictions. These include those funded by other Ministries or Health Canada.

Ontario's 10-year Mental Health and Addictions Strategy, *Open Minds Healthy Minds,* is the provincial approach to support mental health throughout life from childhood to old age and to provide integrated services to support Ontarians and has four guiding goals:

- Improve mental health and well-being for all Ontarians;
- Create healthy, resilient, inclusive communities;
- Identify mental health and addictions problems early and intervene; and
- Provide timely, high-quality, integrated, person-directed health and other human services.

(Source: Ministry of Health and Long-Term Care. Open Minds, Healthy Minds Ontario's Comprehensive Mental Health and Addictions Strategy. June 2011).

The Provincial Mental Health and Addictions Leadership Advisory Council was established in 2014 with a three year mandate to advise the Minister on the implementation of the *Open Minds Healthy Minds* Strategy. In their 2016 report *Moving Forward t*hey identified three recommendations:

- Promote, Prevent, and Intervene Early;
- Close Critical Service Gaps (in particular youth addiction, psychotherapy, and supportive housing); and
- Build Foundations for System Transformation (adopt a set of core mental health and addiction services across Ontario, adopt 10 system-level indicators, develop an evidence-and needs-based funding model for community mental health and addictions services).

To implement the LHIN's Mental Health and Addiction Action Plan, the LHIN reestablished its MHA Advisory Committee with a new mandate and to include a broader membership including representation from Ministry of Child and Youth Services (MCYS) and MCYS Lead Agencies, Indigenous HSPs, and

community MHA providers. The perspective of caregivers and persons with lived experience will be added in 2017/18. This renewed committee has worked to:

- Recommend actions and activities to develop and strengthen a comprehensive integrated MHA system that is aligned with provincial directions and LHIN priorities; is centered on patient/person outcomes and experience, and is based on a foundation of involved and supported primary care; and
- Provide leadership to advance standardization, education, coordination and continuous quality improvement across all sectors within the HNHB LHIN based on best practices.

In 2016-17, the MHA Advisory Committee identified an Action Plan with 10 priority areas (split between ongoing and new) for focused action and/or investments.

Continued Priorities

- Develop an early intervention service delivery model;
- Develop a concurrent disorders capacity building strategy;
- Enhance crisis outreach and support services;
- Complete Schedule 1 bed long stay population review; and
- Improve transitions for children and youth to adult MHA services.

New Priorities

- Identify core MHA services needed at the local, sub-region, and LHIN level;
- Develop and implement an anti-stigma strategy for HSPs;
- Improve access to Schedule 1 beds (Pediatric and adult);
- Identify and address factors that result in repeat ED visits for MHA and improve coordination of care for these individuals; and
- Improve access to supportive housing for persons with MHAs.

In 2016-17, the HNHB LHIN, with the support of the MHA Advisory Committee, worked with health service providers to achieve the following items from the 2016-18 Action Plan:

- Added Early Intervention (EI) Programs to Burlington, Brant, and Haldimand-Norfolk sub-regions, and expanded the program in the Niagara sub-regions to support equitable access across the LHIN area.
- Development and implementation of a transition protocol and resources, reflecting coordination functions, for youth transitioning from inpatient mental health services at McMaster Children's Hospital to adult services at St. Joseph's Healthcare Hamilton was completed. This will ensure smooth transition for individuals in inpatient MH services from pediatric to adult services.
- Improved access to schedule 1 beds by developing a new pathway from community hospitals in the Haldimand-Norfolk and Brant sub-regions to enable direct referral and transfer of high risk children and youth to the McMaster Children's Hospital Emergency Department. This new pathway has reduced the number of handoffs, transitions, and time to access the right level of service.
- Completed a review of long stays in Schedule 1 beds, which included:
    - Established a definition of long inpatient MHA stays (i.e., greater than 90 days in acute beds and greater than 365 days in tertiary beds).

- Gathering data from Schedule 1 hospital sites for individuals with lengths of stay meeting the above criteria.
- Reviewing plans of care and potential for discharge with inpatient care teams and respective community partners, which enabled important discussions about the potential for transition back to the community for individuals when appropriate to ensure individuals are getting the right care at the right place at the right time.

- Developed a concurrent disorders capacity building strategy, which included:
  - Development of an online Concurrent Disorders Foundations module. More than 295 staff participated and received certificates of completion *(Source: HNHB LHIN Annual Business Plan 2017-18).*
  - Implementation of 10 change projects across the HNHB LHIN aligned within a Triple Aim framework of population health improvements for individuals with Concurrent Disorders. This education has helped to ensure that individuals receiving care in the MH and/or addictions system can receive care for co-occurring MH and substance misuse concerns.
- Enhance Crisis Outreach and Support Services by expanding the Mobile Crisis Rapid Response Team (MCRRT) model to Haldimand County and expanding hours of coverage in Niagara. This partnership model between the Ministries of Justice and Health pairs police officers with a mental health worker as first responders to 911 calls involving a person with MHAs. This program model expanded from the original 2015 Hamilton model to include programs in Brant, Halton, Niagara and Norfolk. At the end of December 2016, programs reported having served a total of 3,652 individuals between April 1 and December 312016. During that time, MCRRTs were able to support 2406 diversions from hospital allowing individuals to remain in the community *(Source: HSP 2016-17 Quarter 3 Reports to HNHB LHIN).*

Health and Wellness

The health and wellness of an individual or a community can be influenced by income and social status, social support networks, education, employment and working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, gender and culture. In 2016-17, the HNHB LHIN continued its commitment to address health disparities and advancing health equity through continuing to embed a population health approach and health equity lens into LHIN activities in planning, funding, and the integration of health services.

The *Patients First Act, 2016* further enabled the HNHB LHIN to advanced health equity and reduce disparities and inequities through:

- The implementation of sub-regions, which respects the diversity of local communities in the planning, design, delivery and evaluation of services.
- Establishment of formal linkages with local Public Health Units through the Medical Directors of Health, ensuring that public health expertise can better inform health system planning and decision making.
- Strengthening engagement with Francophone, and Indigenous communities as well as those HSPs that serve the populations in the planning and delivery of health services.

In 2016-17, the HNHB LHIN:

- Incorporated the Health Equity Impact Assessment (HEIA) tool into program planning and development processes.
- Applied a population health approach and health equity lens to planning of programs and services.
- Established a LHIN/Public Health Steering Committee.

Health Equity Impact Assessment

To assist in identifying populations and inequities in programs and services, the HNHB LHIN incorporated the HEIA tool into program planning and development processes. Implementation of the HEIA assists health service providers and the LHIN to integrate health equity considerations into planning and decision making. It will also assist in the identification of unintended impacts of any new or proposed service or program change.

In the HNHB LHIN, completion of the HEIA tool is required for Voluntary Integration submissions and Stage 1 Capital Proposals. In addition, the LHIN may request an HSP complete the HEIA tool when submitting Business Case Proposals, Service Delivery Change Forms (SDCFs), Capital Submissions, and formal evaluations of new programs, services and initiatives. The HEIA will assist the LHIN and its sub-regions in identifying other marginalized or vulnerable populations that require a health equity focus during planning and program development.

Population Health and Health Equity Approach

An example of a population where the LHIN applied a health equity lens was the Migrant Agricultural Worker (MAW) population who work primarily in Norfolk, Haldimand and Niagara. In 2015-16, the LHIN funded two Community Health Centres (Grand River and Quest) to provide primary care services to this population. Funding was used for the implementation and expansion of MAW health clinics in the communities of Virgil, Vineland, Simcoe, Delhi, Beamsville and Brantford. The Nurse Practitioner primary care-based model is supported by a team of professionals including a Registered Nurse, an outreach worker, a translator, and volunteers. In 2016-17, the MAW programs served 850 individuals and the programs continue to demonstrate success by exceeding performance areas measured.

Public Health

In October 2016, the HNHB LHIN Public Health Steering Committee was established with representation from each of the five local Public Health Units and LHIN leadership.

The Steering Committee focused primarily on the alignment of mandates. Emphasis has also been placed on the involvement of public health in database planning at the sub-region level. This has included the development of 12 new population health indicators to profile at the sub-region and community level.

Prevention and Management of Complex/Chronic Conditions

Ontario's population is aging and while people are living longer, a growing number of older adults are living with the combined effects of a decline in physical function, medical problems and the development of chronic health conditions.

The HNHB LHIN is working with HSPs and other stakeholders with a focus on specific complex/chronic conditions to:

- Provide people with the knowledge and tools to manage their chronic conditions.
- Improve access to services and specialist care, including priority populations such as Indigenous Peoples.
- Increase access to evidence-based models of care that demonstrate improved outcomes.
- Optimize opportunities to increase access to community based care.

Diabetes

As of April 2015, there were 143,317 adults living with diabetes in the HNHB LHIN, representing 12.1% of the LHIN's adult population. Among the 14 LHINs across the province, the HNHB LHIN has the third largest adult population living with diabetes *(Source: Diabetes System Indicators 2016 HNHB LHIN Website Accessed February 19, 2017).*

Health care professionals from eight HNHB LHIN Adult Diabetes Education Programs (DEP), two Indigenous DEPs, one Indigenous diabetes initiative and four pediatric DEPs worked together to improve access to DEPs for LHIN residents. In 2016-17, the following was achieved:

- Developed and implemented a coordinated access model to standardize and improve access to DEPs. This model includes one standardized diabetes referral form and is operationalized through three lead agencies. This model enables people to access a DEP through self-referral.
- Implemented a LHIN-led central communication media strategy to highlight the value of local DEP's among health care professionals. This included several key accomplishments such as:
    - Jointly released media through Twitter, generic newsletter content and website design.
    - Release of three "Distinct Voices in the Community" videos in Fall 2016, featuring stories from rural, Indigenous, and Francophone DEPs.
    - Messaging around regional diabetes services was simultaneously sent to media, including radio, print and television, which resulted in media interviews and newspaper articles highlighting individual success stories of people with diabetes.
- Pediatric and Adult DEP members collaboratively developed a process to improve communication between youth with diabetes, their primary caregivers, the pediatric diabetes care team and adult diabetes care team, utilizing standards from *Transition to Adult Care Working Group Recommendations Report* (Feb 2016). The process is anticipated to be implemented throughout 2017, with an evaluation in the next fiscal year.

Empowering Clients through Self-Referral to Diabetes Education Services

As of December 2016, 97 individuals utilized the self-referral option to access DEPs through the centralized access model.

- As of December 2016, 17, 804 individuals received service from HNHB LHIN funded DEPs *(Source: DEPs Activity Reports).*
- Improved access to specialized services for DEP clients through partnerships and innovations:
    - Pediatric DEP (PDEP) common criteria for referral to tertiary care which facilitates timely referral for consultation to the McMaster Children's Hospital PDEP for complex children with Type 1 diabetes who are being cared for at local PDEPs.
    - Partnership with Six Nations DEP and OTN Ophthalmology to provide on-site dilated pupil exams to improve access with planned start date in 2017.
    - In 2017, SJHH Pain Clinic and SJHH Bariatric Program will start referring clients with diabetes to local DEP's as well as making recommendation to primary care physicians.
- Investigation of OTN options by DEPs, such as PCVC to dramatically enhance opportunities to reach individuals with diabetes where they reside:
    - Six Nations investigating PCVC with out of town gestational clinic individuals.
    - SJHH investigating PCVC for post kidney transplant visits with individuals who live outside of Hamilton, yet require support for diabetes related conditions such as medication adjustment, foot care, eye exams.

Integrated Stroke Recovery System

By increasing access to integrated best practice stroke care, the HNHB LHIN continued to show improvements in stroke indicators in 2016-17. The best practice evidence indicates persons post stroke who receive their care on a stroke unit by a dedicated inter-professional team are more likely to be alive, independent, and living at home one year post stroke *(Source: Stroke Unit Trialists' Collaboration. Organized inpatient (stroke unit) care for stroke. Cochrane Database of Systematic Reviews 2007, Issue 4. Canadian Best Practice Guidelines for Stroke) Care, 2010).* For this reason, the HNHB LHIN partnered with the Central South Regional Stroke Network (CSRSN) and stroke care providers to increase access to stroke unit care and to build an integrated stroke recovery system.

- Integrated stroke unit (ISU) care has been implemented in Hamilton, Brant, Haldimand and Norfolk. The establishment of an ISU at BCHS in June 2013 has been shown to contribute to consistent improved access to acute stroke unit care at BCHS from 0% to 85.6% *(Source: Brant Community Health Care System schedule 1 Q2 2016/17 report to the HNHB LHIN).* In addition, the opening of the ISU has resulted in an increased proportion of patients discharged to inpatient rehabilitation in the HNHB LHIN to from 39.1 to 49.3% *(Source: Ontario Stroke Network Report Card 2014-15).*
- In 2016, NHS launched a second acute stroke unit at the St. Catharines hospital site and integrated acute stroke unit care from the Welland hospital site.
- The HNHB LHIN has engaged with JBH and the CSRSN to develop and implement an ISU model in Burlington and the plan for the development of the integrated stroke unit was presented to the Regional Stroke Steering Committee.
- A successful Community Stroke Rehabilitation Model (CSRM) is ongoing in Brant, Haldimand and Norfolk. The model provides access to best practice in-home community rehabilitative stroke care for individuals who live beyond 30 minutes of an outpatient therapy centre and/or do not have the tolerance to travel. Care is delivered in a timely way from a consistent expert stroke

team providing intensive best practice stroke care. In 2016-17, 60 individuals received best practice intensive community stroke rehabilitation in the home *(Source: Community Care Access Centre Community Stroke Rehabilitation Model Q3 2016-17 report)*. The Brant, Haldimand and Norfolk CSRM results based on the average number of 32 visits have been applied to the development of a CSRM in Hamilton.

- The Ontario Stroke Network (OSN) annual report card demonstrated improvements in eight indicators from the previous report card. There has been a significant reduction in 30-day mortality rates from to 11.3 from 13.7 per 1,000 population in the previous year. The HNHB LHIN is the top performer for two indicators related to tissue Plasminogen Activator, the clot-busting medication known as tPA: door-to-needle time and proportion of individuals who receive tPA. The implementation of the CSRM contributed to significant improvements in the number of CCAC visits for individuals with stroke/TIA to 6.8 visits compared to 5.1 visits the previous year *(Source: Ontario Stroke Network Report Card 2014-15)*.

Scott' Story

Scott MacPherson, a 36-year-old chiropractor in St. Catharines, was in his office with a patient when he suddenly felt his left arm go numb. He began to feel dizzy and lost the use of his left leg. He made his way into the hallway where his wife saw him and immediately called 911. Paramedics arrived quickly and after an assessment, realized Scott was having a stroke. Scott was taken to Greater Niagara General Hospital in Niagara Falls where he received the clot-busting drug tPA and was then rushed, to Hamilton General Hospital where the underwent a procedure to remove the blood clot in his brain. Scott began doing exercises the day following his clot retrieval surgery, and continued rehabilitation after he left hospital. Within six weeks, Scott had amazingly made a full recovery.

A video detailing Scott's story can be found here: https://youtu.be/JhFPmUt6oA

Dementia

The Alzheimer's Society projects that one in ten people over the age of 65 are living with Alzheimer's or other dementias. Based on a 2012 report by the Alzheimer's Society of Ontario, approximately 265,000 people are over the age of 65, which would mean that potentially 26,500 individuals are living with dementia *(Source: Alzheimer Society of Ontario. Dementia Evidence Brief: HNHB LHIN 2012. HNHN LHIN Presentation on Dementia to MOHLTC September 11, 2015)*.

Family members and/or friends caring for a person with moderate to severe cognitive impairment are more likely to report physical, emotional, financial or social distress *(Sources: Sinha, S. K. Living Longer Living Well, MOHLTC, December 2012; Canadian Institute of Health Information, Supporting Informal Caregiver-The Heart of Home Care August 2010; Alzheimer's Society of Ontario, Dementia Evidence Brief: HNHB LHIN. July 2012)*. The LHIN funds a number of programs geared to caregivers

providing care for persons with cognitive impairment, including adult day programs, overnight bedded respite services and in-home respite care. In 2016-17, select initiatives included:

- The ongoing development of an HNHB dementia strategy in consultation with multiple LHIN stakeholders focused on a local approach to stigma-reduction, public awareness, and "living well" with Alzheimer's disease and other dementias;
- A Self-Care for the Caregiver Program which consists of a 16-week course for caregivers of persons living with dementia and aims to strengthen and expand caregiver coping strategies, and increase the level of resilience in caregivers. Initial results comparing caregiver burden pre and post-completion of this program demonstrated an average reduction in burden of 24%. Empowering caregivers allows them to care for their loved ones longer at home and in the community; and
- An expansion of respite services as a result of $2,084,300 in new funding to the HNHB CCAC that increased access to respite care for 939 families across the LHIN. While this investment is not limited to caregivers supporting persons with moderate to severe dementia it is focused on caregivers supporting persons with complex conditions.

Palliative Care

Hospice Palliative Care, often referred to as "palliative care" is a philosophy of care that aims to relieve suffering and improve the quality of living and dying.

In March 2016, the Ministry announced the establishment of the Ontario Palliative Care Network (OPCN). Accountable to the Ministry, the OPCN is an organized partnership of community stakeholders, health service providers and health system planners responsible for the development of a coordinated, standardized approach to the delivery of hospice palliative care services in the province *(Source: OPCN Backgrounder and Key Messages, July 2016).*

Ontario Palliative Care Network

In 2016-17, the HNHB LHIN, in partnership with the Regional Cancer Centre Vice President worked with stakeholders to transition the LHIN's existing Regional Palliative Care Council to the new Regional Palliative Care Network (RPCN) governance model. The HNHB RPCN provides leadership and structure to facilitate the development of hospice palliative care program within the LHIN that supports the provincial vision:

"Adults and children with progressive life-limiting illness, their families and their caregivers will receive the holistic, proactive, timely and continuous care and support they need, through the entire spectrum of care both preceding and following death to help them live as they choose, and optimize their quality of life, comfort, dignity and security."

During the transition, the RPCN continued to advance the LHIN's hospice palliative care 2015-2018 work plan and priorities, including the following achievements:

- Recruited three Family Health Teams (FHTs), comprising of 20 primary care physicians, to participate in the early identification project. The project was implemented in Hamilton, Niagara and Niagara-on-the-Lake in September 2016 with 20 primary care physicians. Sites joined

starting in January 2016 and the last site started in September 2016. Quality improvement goals and measures were developed with project sites, including:

  - Testing the use of the Early Identification Guide to help identify patients who could benefit from a palliative approach to care.
  - Co-developing a reliable process for: assignment of a care coordinator for each patient to support continuous care coordination; assessment of the patient's and family's palliative care needs and goals of care; accessing community services along the illness trajectory.
- Preliminary outcomes from early identification project participants has included:
  - Praise for the early identification guide by family physicians and care coordinators in identifying patients not typically considered as requiring a palliative approach to care (i.e. non-cancer populations).
  - The ability of the guide to assist and promote early and ongoing communication between primary care teams, patients, and their families regarding the patients' care plan along the care trajectory.
  - Increased awareness amongst patients and their families in knowing who to call for assistance.
  - Having the specialists accessible for consultation/mentorship supported the primary care physicians to provide continuous practice and offer a palliative approach to care for their patients.
- Implemented collaborative and consultative models to work with and support generalist team members to deliver palliative care including Palliative Care Outreach Teams and Community Palliative (Physician) On-Call. This included the completion of an asset survey related to specialized palliative care resources and a Regional Education Plan to support capacity building with primary/generalist team members.
- Increased access to residential hospice beds by supporting four additional beds at Brantford's Stedman Community Hospice for a total of 10 beds to serve approximately 100 more clients and their family each year.
- Developed a Regional Palliative Care Education Plan through the RPCN Education Working Group. The plan informed a focused education plan that was supported with new one-time funds and completed over a five week period. Education/training included: provision of *Learning Essential Approaches to Palliative* care (LEAP) training. As of March 31, 2017, LEAP training was completed by 184 learners including CCAC Care Coordinators and Six Nations of Grand River Care Coordinators. In addition 23 specialist palliative care physicians and 33 specialist palliative care nurses participated in a

Learning Essential Approaches to Palliative Care

"The patient expressed feelings of despondency and felt as though 'everyone had given up' on her. Using communication techniques acquired through the LEAP mini session, the community nurse was able to explain the palliative care approach, with the focus on symptom control and supportive care. The CCAC Care Coordinator was then able to follow up with a call to the patient to discuss additional supportive services. The patient agreed, and was very pleased to accept the services of the CCAC Palliative Nurse Practitioner. Our team looks forward to using this approach to continue to bring the right supports and care to our patients in their home.

- CCAC Care Coordinator (LEAP Mini Session Participant)

(Adapted from feedback received through session evaluation)

specialist palliative care workshop. The workshop focused on how the specialist can support collaborative practice and capacity building with primary care providers.

- Increased access to the Hospice Volunteer Services program, which educates volunteers to provide emotional, social and spiritual support to individuals who are living with a life-limiting illness and/or their caregivers, through a new $133,000 investment.

The LHIN continues to support patients who are palliative and their family in the community, hospitals and LTCH settings.

- As of December 2016, 603 individuals received shift nursing, 577 individuals received personal support services and 331 group education sessions were held at residential hospices *(Source CCAC 2016-17 Q3 SR Report).*
- As of December 2016, Palliative Care CCAC Nurse Practitioners served 477 individuals.
- As of December 2016, CCAC provided in-home end of life care to 4,217 individuals *(Source CCAC Email May 3, 2017).*
- As of December 2016, Visiting Hospice Service Providers made a total of 12,368 visits to 1,518 individuals and conducted 225 group sessions attended by a total of 1,689 individuals *(Source CSS Agencies SRI Q3 Reports).*
- As of September 2016, there were 117 Hospital Designated Palliative/End of Life beds and 728 Discharges of which 605 Discharge Disposition Death (83%) *(Source Complex Care Reporting from HNHB hospital sites).*

The HNHB LHIN recognizes that changes to the quality, availability and integrated delivery of palliative care services in HNHB communities will lead to improvements in the patient and caregiver experience while working to create a sustainable and efficient health care system for future generations.

Behavioural Supports Ontario

The Ontario Behavioural Supports Ontario (BSO) Strategy is built on a framework of principles guiding the development of quality health services for people who exhibit or are at risk of exhibiting responsive behaviours. The HNHB LHIN's BSO strategy is guided by the following statement developed by LHIN providers as represented of the voice of the individual with cognitive impairment.

Behavioural Supports Ontario

"I am who I am, so help me to continue to be me"

The HNHB's BSO Strategy was developed to provide support the person and family/caregiver as they transition across the health care continuum. The person and family/caregiver are central to supports that surround them. The Strategy consists of:

- BSO Connect – a single point of information and referral for clients, caregivers, and healthcare providers, pulling services toward clients. BSO Connect was operated by the HNHB CCAC.
- BSO Community Outreach Team (COT) – five teams with geriatric expertise embedded within existing community crisis teams providing 'just in time' support to individuals with, or at risk of, developing responsive behaviours and linking them to longer term support.
- Integrated Community Lead (ICL) Service Model – one community agency acts as the single point of contact for BSO clients.
- BSO Hospital Clinical Leads – four BSO Clinical Leads, employed by four host hospital organizations, NHS, HHS, SJHH and BCHS. Core functions of the Clinical Leads include collaborating with hospital staff in the development of patient behavioural care plans, patient transition plans, and provider capacity building.
- BSO Long-Term Care (LTC) Mobile Team – five multi-disciplinary teams, serving the LHIN's 85 long-term care homes.

In 2016-17 new investments allowed LHIN to:

- Introduce a new LTC transitional model of care that will further enhance supports for clients, families/caregivers; and
- Enhance existing programs in the community and hospital.

At the heart of the new and existing programs, was the focus to improve the patient and family experience by putting their needs at the centre of all BSO services and supports that span across the health care continuum.

A collaborative approach with extensive stakeholder engagement was undertaken to support the planning, development and implementation of new and enhanced model of care. These included:

- Development of a new enhanced support model for transitions to LTCH. The new model referred to as *Teams Assisting Clients through Transitions or TACT* consist of six full time regulated health professions. These teams will focus on a subset of the most complex clients with challenging behaviours awaiting LTC placement. The TACT model intensively supports those clients and the LTCH staff for a minimum of six weeks post LTC admission.
- Enhancement of the BSO COT in Hamilton with the introduction of a new role with the community team that focuses on retirement home clients and building capacity within those settings.
- Addition of a BSO Hospital Clinical Lead to support Brantford, Haldimand and Norfolk

As the new BSO funds were provided mid-year, LHINs were able to utilize these funds for advance education for health care professions serving individuals with or at risk of developing responsive behaviours. An extensive education plan was implemented with a goal to ensure the education and training provided would meet the priority learning needs of care providers, was evidence-based, was transferable to the care setting, had impact that was measurable and was sustainable.

BSO 2016-17 Key Successes

BSO Connect:

- 1,643 clients served as of March 31, 2017 (4,911 since April 2012);
- 100% of caregivers/clients connected to service/support after calling BSO Connect; and
- 55.2% of those clients had no prior services before calling BSO Connect.

BSO Community Outreach Teams:

- 1,452 clients received crisis support as of March 31, 2017 (5,405 since program implementation April 1, 2012);
- 426 family members and informal care providers were supported in the community; and
- Members of the Community Outreach Teams attended local Complex Case/ situation tables LHIN wide to collaborate with community partners to support clients with complex needs necessitating multi-agency support.

BSO COT: Supporting Clients and the People Around Them

"The Behavioural Support Ontario Community Outreach Team's support last week was so very much appreciated given it was a very stressful and emotional time for the family."

"Their presence really helped my father and myself look forward to a better future for my father."

- *Jodie, daughter of client served by BSO COT*

BSO LTC Mobile Team:

- 2,959 referrals received as of March 31, 2017 (11,625 since April 1, 2012).
- 1,477 family members/ informal care partners supported in the Long-Term Care sector
- 1,200 clients were supported through transitions to/from LTC, Community, Acute Care, and/or Tertiary Care settings as of March 31, 2017. Transition referrals continue to comprise a large proportion of the referrals to the LTC Mobile team (40.6% of referrals).

BSO LTC Mobile Team: Bringing a Novel Perspective to LTC Residents' Care

"The external team provides a great resource to the Home as the Mobile Team are dedicated to what they do, and are well trained and versed in managing and responding to behaviours."

- Laura, Registered Nurse, Parkview Nursing Centre, Hamilton

- Building capacity among care providers supporting this population is a key pillar in the provincial framework.
- In 2016-17, the BSO strategy supported 966 education sessions with 9,299 participants learning best practices for assisting the BSO population.

BSO Hospital Clinical Leaders:

- 553 referrals were received for hospital inpatients in 2016-17 by three Clinical Leaders.
- 437 patient cases closed. Patients were discharged from hospital, primarily to transitional beds (119 patients), LTC beds (95 patients), private homes (43 patients) and retirement homes (37 patients).

- 21 patients were diverted from resource-intensive care settings (i.e., Behavioural Assessment Units) and placed into less highly-resourced settings.
- The length of stay patients waited for an alternate level of care (ALC) decreased for patients in all HNHB Hospitals identified in ALC-IS data as Specialized Care Needs - Behavioural. When comparing the average number of ALC days per patient with responsive behaviours as a barrier to discharge, it is evident that the Clinical Lead role is correlated with a decrease in ALC days:
    - 2013-14 (no BSO Clinical Leader): 34.6 days/ patient
    - 2014-15 (no BSO Clinical Leader): 34.5 days/ patient
    - 2015-16 (with BSO Clinical Leader): 27.2 days/ patient
    - 2016-17 (with BSO Clinical Leader): 22.8 days/ patient

BSO Clinical Leaders: Building capacity while supporting the needs of inpatients

"The presence of this role assists not only our discharge plans but also ensures ward staff are equipped to use best practices in the form of behavioural strategies for some of our most vulnerable patients."

- Jennifer Radigan, Registered Social Worker, Acute Medicine Unit

BSO 2016-17 Education Plan:

- 41 education sessions were held at locations across the LHIN with the following participants:
    - 607 staff from the Long-Term Care sector
    - 434 staff from the Community sector
    - 80 staff from the hospital sector
- LTC homes across the LHIN were encouraged to select 1-2 Behavioural Leads in their home to complete up to four training sessions so that they could lead the care of people with responsive behaviours in their home. 75 of 86 of homes (87%) have appointed Behavioural Leads.

Developing Behavioural Leads Through Education

"Behavioural Leads can assess, begin interventions, and do everything in the homes power prior to calling the BSO team. The home will be able to understand how to manage behaviours better with a behavioural lead"

- Katelyn Dunham, Behavioural Lead, Orchard

Integrated Community Lead (ICL) Model:

- The BSO ICL approach has been adopted throughout the HNHB LHIN as the approach to care for any complex patient requiring multiple service providers to work in a collaborative and integrative manner. Using the same framework and principles developed through the BSO Strategy, the ICL approach is now a language and philosophy employed by providers to describe the care approach for Health Links, complex Mental Health, as well as BSO patient populations, and is improved and sustained through hub regional community tables.

(Source for all BSO data: HNHB Strategic Lead Office)

Advancing eHealth in the HNHB LHIN

Over the past year, a number of inter-related Digital Health initiatives that support patient care were achieved. The Health Information Technology Services (HITS) eHealth Office at Hamilton Health Sciences manages the advancement of regional eHealth initiatives to improve the delivery of healthcare in the HNHB LHIN. The eHealth Office provides strategic planning, stakeholder engagement, communication, change management and adoption (CM&A), proposal preparations and negotiation, and integration planning and implementation for regional eHealth initiatives.

It is not unusual for patients and their families living in our LHIN to see multiple health professional across multiple sub-regions. ClinicalConnect is a regional electronic health record that allows a patient's record and investigations to be accessed by their family physicians and consultants enabling more timely decision-making and diagnosis as well as preventing the requirement to duplicate various investigations. In the HNHB LHIN, there are 16,884 registered users, 21 hospitals sites, one CCAC, 1,142 primary/secondary care organizations (including Community Health Centres and LTC homes), 133 Community Support Service agencies and two Public Health Units.

Community lab services are a convenient options for patients who require blood work. This community lab data is now available to all health care providers with access to ClinicalConnect. Once again, this prevents duplication of testing and faster access for family physicians and consultants to receive these results.

Other Digital Health initiatives to improve the patient experience include *eConsult/eVisits/Tele-home* and *eShift*.

- *eConsult* enables family physicians and specialists to consult with one another across the province so patients get the best care possible without always having to travel to see a specialist. Advice from the specialist can be sent electronically to the family physician, either to start a particular treatment pathway, or suggest changes to current treatment or refer for further investigation. For many patients, traveling to specialty appointments is difficult.
- With *eVisit* (Physician/Clinician to Patient) the use of Personal Computer Video Conferencing provides patients a "virtual" visit without the need to physically go to an office.
- The *Tele-home care* remote patient monitoring model is part of SJHH's Integrated Coordinated Care (ICC) Program for COPD or Congestive Heart Failure (CHF) patients. This allows patients to connect directly with their Case Manager.
- *eShift* enables Registered Nurses in the community to care for multiple patients at the same time by assessing, monitoring, and directing interventions to Personal Support Workers at the patient's side or arrange for a nurse to attend when needed.

Integrated Decision Support (IDS) Business Intelligence Solution

IDS is a multi-LHIN integrated decision support data warehouse and business intelligence solution that provides for both system-wide and operational analytics to over 70 HSPs and LHIN offices. It consists of a live data repository, analytical tools and reporting services, and is operational in six LHINs (HNHB, Toronto Central, South West, Waterloo Wellington, Mississauga-Halton, and Erie St. Clair).

There are more than 1,000 active users in IDS, which houses more than 36.7 million patient encounter records (6 million unique patients) linked by a master LHIN number, facilitating collaboration between sectors that are responsible for the patients' healthcare journey.

As the HNHB LHIN continued to prepare for the Patients First Act, this IDS Solution was extremely helpful in providing accurate data, analysis, and insights into this LHIN's population health and predictive analysis.

Improving System-Wide Patient Flow and Timely Access to Emergency Department

Patient flow is defined as an individual's movement through the health care continuum *(Source: Institute for Healthcare Improvement)*. Patient flow focuses on the transition of individuals from community to acute in-patient hospital care and acute in-patient care to post-acute care (like rehabilitation) or home. While it is not unexpected that situations will occur where individuals will experience a wait across the continuum, issues arise when individuals experience long waits in a hospital setting or when a large number of individuals wait in hospital for a post-acute care setting.

Patient Flow

The LHIN measures overall patient flow in hospitals through two key performance indicators: Alternate Level of Care (ALC) rate and Emergency Department (ED) Length of Stay (LOS).

ALC rate refers to the proportion of in-patient days in acute and post-acute hospital care settings that are spent as ALC in a specific time period. In 2016-17, the ALC rate ranged from 13.8% to 14.5%, representing an increase over 2015-16 (13.49% to 13.71%).

Provincial ALC Definition

When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).

(Source: Access to Care - Cancer Care Ontario)

On average in 2016-17 there were 487 people waiting in hospital for an alternate level of care, this represents 37 more people compared to the 2015-16 monthly average of 450 people *(Source: Access to Care, ALC Trending Report 2017-02)*. During this same time period, there was also an increase in overall ED visits and ED visits for more complex patients (see section 8.2 for further details).

Strategies to reduce the number of days individuals wait in hospital for an alternate level of care included:

- Optimizing and exploring opportunities to enhance access to community-based transitional programs for existing and new populations – *see section 8.3 Transitional Care Model.*
- Decreasing ALC days to Behavioural Health Transition Units (BHTU) through BSO Clinical Leads ability to divert clients and successfully transitioning clients from hospital to community (including LTC) and improving flow through the BHTU's.

- Decreasing ALC days for individuals who are at risk of exhibiting responsive behaviours due to cognitive impairment from dementia or other neurological conditions by having a supportive plan when transitioning across the health system.
- Implementation of the Home First Refresh ALC avoidance processes across all hospital corporations, including:
    - Early engagement and discharge planning – 48 hour conversation for admitted patients;
    - Referrals to CCAC 48 hours prior to ALC designation; and
    - Family meetings prior to ALC designation.
- Implementation of electronic solutions to support the implementation of the provincial Resource Matching and Referral (RM&R) standards for Acute to CCAC – *Interface built leveraging ClinicalConnect, Go Live planned for all hospital sites in 2016/17.*
- Implement electronic solution for ED Notification to CCAC, hospital and primary care - *The E-Notification projected go-live will be completed in three waves from June – October of 2017.*

ED Length of Stay / Key Activities to Reduce ED Demand and Length of Stay

ED LOS reflects the total amount of time individuals spend in the ED, from the time they register or are triaged (whichever occurs first) to the time when they leave the ED or are admitted to an inpatient hospital bed. During this time, the person sees the medical staff and receives care.

There are 13 ED sites across the HNHB LHIN, which include sites dedicated to pediatrics, trauma, cancer, cardiovascular, stroke, burns, and neurosurgery. Eight of these sites participate in the MOHLTC's Pay for Results initiative which aims to reduce ED wait times while measuring a variety of indictors. There are 5 urgent care centers across the LHIN to assist in treating those with less serious or uncomplicated conditions and reduce the demand for the larger EDs.

In 2016-17, HNHB EDs experienced significant demand with overall ED visits increasing 32% since 2008 and ED visits for more complex patients increasing by 67%. Despite these extreme pressures, 81% of complex patients were seen within the target of 8 hours and 86% of minor/uncomplicated patients were seen within the target of 4 hours *(Source: Access to Care, ER Fiscal Year Report (2016/17).*

Improvements in the ED LOS to inpatient bed has been noted at McMaster Children's Hospital (37% improvement) and Haldimand War Memorial Hospital (15% improvement) comparing previous fiscal year (2015-16) to Year to Date 2016-17: *(Source: Access to Care, ER Fiscal Year Report (2016/17).*

In 2016, three HNHB hospital sites received outstanding ED performance letters from the MOHLTC recognizing achievements in the following areas:

Greatest Improvement in 90th percentile ED LOS:

- ✓ McMaster Children's Hospital – pediatric hospital group
- ✓ Joseph Brant Hospital – medium volume community hospital group

Lowest 90th percentile ED LOS:

- ✓ Haldimand War Memorial Hospital – low volume hospital group

Initiatives to retain HNHB LHIN residents in LTCHs rather than EDs have been successful as demonstrated by the HNHB LHIN having the second lowest ED visit rate for potentially avoidable ED visits for long-term care residents compared to all other LHINs from Q3 2015-16 to Q2 2016/17 *(Source:*

Health Analytics Branch, MOHLTC) Nurse-led outreach teams, attending nurse practitioners and palliative shared care outreach teams are all initiatives imperative to this success.

In 2016-17, the Emergency Services Steering Committee (ESSC), in collaboration with the LHIN, continued to focus on admission avoidance and quality improvement strategies that improved the flow of patients in the ED and the experience of those who needed ED care.

Highlights include:

- Approval of a LHIN-wide eNotification project: the development of a real-time electronic messages/reports to providers notifying them that their patient has presented to the ED.
- Evaluating Long-Term Care Homes Intravenous Therapy Experiences (LIVE) Study: evaluating LTCHs experiences with intravenous (IV) therapy along with the development of clinical pathways. This study obtained key stakeholder perceptions of on-site IV therapy in long-term care homes. A key outcome was the development of two clinical pathways for respiratory tract infections and urinary tract infections along with educational videos for long-term care home staff and an IV therapy manual which were all disseminated to the HNHB LHIN long-term care homes.
- Collaborative Short Stay Unit: partnership between Joseph Brant Hospital and CCAC to establish a short stay space that focused on transitions back to the community in order to prevent admissions to hospital.
- Initiatives identified in 2016-17 to improve patient flow and reduce ED LOS were grouped into two categories initiatives that:
    - Improved Transitions in Care
    - Maintain or improve functional status

Transitions in Care

Once their medical care is complete, the majority of individuals admitted to hospital, are discharged home. For various reasons, a small percent of patients are unable to return to their pre-hospital living arrangement. Waiting in hospital for an ALC, however, can place an individual at risk for functional decline and other hospital related complications.

The HNHB Transitional Care Service Model (Program) is a congregate (bedded) model of care within retirement homes or assisted living settings that allows for 24-hour personal support worker supported environments funded by the CCAC or the HNHB LHIN. The Program is an extension of community care, not hospital care, which has evolved through committed collaboration and levering existing relationships and capacity in the community. The program provides an alternative,

Client and Family Experience in TCP

"After eight weeks in hospital, in spite of her receiving excellent care, my wife had lost much of her mobility and ability to care for herself. Three weeks at Wesley, through the tireless efforts of your PSS Workers and Therapeutic Recreationist she has begun to regain mobility and personality and in the past 3-4 days has made considerable progress in beginning to walk again!"

"The term 'transitional' falls short in reflecting the high level of restorative care that she has received."

- Quote from Experience Survey

community based option for individuals ready for discharge from acute care hospital beds but who not ready or unable to return home to pre-hospital living arrangements. Individuals accessing the program are medically stable and ready for discharge from hospital. The program provides an environment that supports individuals to recover their strength and independence along with the time to be able to plan for the most appropriate permanent, community-based living arrangements.

The Transitional Care Program (TCP) was introduced in October 2014 in response to increased reports from LHIN hospitals of severe patient flow pressures. As of April 2017, TCP has expanded to include 15 sites for a total of 206 beds across Hamilton, Burlington, Niagara and Brant communities *(Source: CCAC Daily Idle Bed Report, March 24 2016).*

As of March 31, 2017, TCP reported:

- 2,009 admissions and 1,801 discharges.
- Accumulated length-of-stay for discharged residents represents the equivalent of 97,168 avoided hospital ALC days or 266 hospital beds.
- 73% discharged within 60 days, 27% over 60 days.
- Turnover rate at 90%.
- 11% of individuals are discharged from the program to a retirement homes or assisted living setting or return home.

(Source: TCP Executive Lead March 31, 2017 Report; HNHB LHIN Transitional Care Service Model Report on HNHB's Experience February 2017)

From April 2016 through March 2017 there were 938 admissions and 934 discharges. All occupied beds on March 31, 2017, had a total of 11,828 days (translate saved ALC days).

Maintain or Improve Functional Status

Seniors Mobile Assess Restore Teams

In 2016-17, the Smart Mobile Assess Restore Team (SMART) model continued across six HNHB LHIN hospital sites. This program targets seniors who are at risk of functional decline at their time of admission to hospital. The SMART model provides hospitalized seniors that have restorative capacity with access to a mobile, dedicated, inter-professional team-based, rehabilitative care model. Interventions are provided to patients in their current location i.e. Emergency Department (ED) or acute care. The SMART model integrates services with the provision of rehabilitative care in parallel with acute medical care.

An evaluation of the SMART program for its impact on alternate level of care (ALC)

Mrs. F is a 96-year-old woman who was admitted after suffering injuries and damage to muscle tissue after a fall. She lives alone in an apartment, walked with a rollator and, with ADLs, was completely independent. Upon admission, she was fearful and anxious, required the assistance of two people to stand and was and unable to unable to ambulate even with assistance. Within 8 days of therapy, she was safe for discharge home.

Lillian is 87 years old and she was admitted to hospital with congestive heart value. She feared she would have to go to a nursing home following hospital however she received SMART care and she has improved and maintained her independence and she will be returning to living at home. Lillian's video story can be found here: https://youtu.be/TiNEpsTcvHg.

designation/days/need for restorative programs for specific populations showed positive results:

- 3,923 individuals were served by SMART teams in fiscal year 2016-17.
- 89% of individuals were discharged home directly from acute care.
- An average 33% increase in the extent to which individuals can function independently at home as measured by pre and post administration of the Barthel activities of daily living index.
- For individuals who required rehabilitative care within hospital following acute care, a shorter period of time in hospital (an average of four days) was required compared to individuals who were similar (individuals with a similar case mix group).
- 27% decrease in ALC days for patients discharged to Complex Care-Low Tolerance Long Duration (LTLD) was noted in HNHB LHIN level data (6,738 ALC days for April 2016-March 2017 compared to 9,253 ALC days April 2014 – March 2015).
- The SMART program can generate significant savings and value throughout a patient's rehabilitative care journey by:
    - Reducing the time required for post-acute rehabilitative care;
    - Decreasing the need for rehabilitative care within hospital; and
    - Decreasing the amount of time individuals wait for a rehabilitative level of care.
- SMART teams and SMART leaders have the ability to implement successful rehabilitative care initiatives that have the potential to change the trajectory of an individual's healthcare journey and life story from a potential discharge from hospital to a long term care home to a discharge from hospital to home as evidenced by the patient stories.

(Sources: Six hospital health service provider SMART reports (Q4 2016/17), roll-up data validation pending; HNHB LHIN level data for April 2016-March 2017, compared to April 2014-March 2015. Access to care iPort.)

Rehabilitative Care Alliance (RCA)

In 2016-17, Ontario LHINs supported a second two year mandate for the Rehabilitative Care Alliance (RCA). The provincial RCA is a collaborative effort funded by Ontario's 14 LHINs. The RCA works with partners across the province to strengthen and standardize rehabilitative care through better planning, performance management and evaluation and by integrating best practices across the care continuum. During the first two year mandate, the provincial RCA developed standardized definitions and eligibility criteria for rehabilitative care. A provincial capacity planning framework was also developed to promote consistency in planning rehabilitative care services across the province.

In 2016-17, a local HNHB LHIN Rehabilitative Care Alliance (RCA) virtual network was established to implement the provincial standard definitions for rehabilitative care. The HNHB LHIN RCA was established to implement the work of the provincial RCA at the local HNHB LHIN and sub region level. As of March 31, 2017, the local HNHB RCA partners have adopted and implemented the provincial standard definitions and eligibility criteria for rehabilitative care provided in hospital beds and short stay long term care beds, as well as for rehabilitative care provided in the community. The purpose of adopting standard definitions for rehabilitative care across the province is to increase the understanding of patients,

family members and referring partners related to the population served, the services available and what to expect within rehabilitative care. Rehabilitative care programs support individuals who need access to care to regain or maintain their optimal functional status.

There are four levels of rehabilitative care provided within hospital and short stay long term care beds:

- Rehabilitation, high and low intensity;
- Activation Restoration;
- Short-Term Complex Medical Management; and
- Long-Term Complex Medical Management.

People are usually admitted from the hospital following an acute event, however, individuals are also admitted directly from the community into the activation restoration level of care.

Bedded Referral Option Tools have been developed for individuals who refer to rehabilitative care programs. A referral option tool has been developed for each HNHB LHIN sub-region. There are two levels of community rehabilitative care:

- Progression
- Maintenance

Some community rehabilitative care programs in the HNHB LHIN provide both a progression and a maintenance level of rehabilitative care. For full details, see the complete Definitions Framework for Community-Based Rehabilitative Care http://rehabcarealliance.ca/definitions-1.

The Niagara RCA sub-region task group has applied the provincial capacity planning framework to guide planning for rehabilitative care services in Niagara. The Niagara RCA group continues to build on this work related to future planning for rehabilitative care services in Niagara.

Home and Community Care

The preference of most people, regardless of age, is to remain independent and in their own homes for as long as they can *(Source: Bringing Care Home. (2015). Report of the Expert Group on Home and Community Care to the Minister of Health and Long-Term Care: Ontario).* Some individuals require support to make this possible, which can include one or more of the following: nursing, physiotherapy, occupational therapy, speech language therapy, personal support services, respite, homemaking, home healthcare supplies and healthy eating. Access to home and community care can result in shorter hospital stays and even delay or avoid the need for admission to an institutional setting (such as a hospital or long-term care). Home and community care is necessary for our health system to deliver on the promise of right care, right time and right place.

The introduction of the *Patients First Act, 2016,* significantly changed how home and community care services are administered in Ontario. In 2016-17, the HNHB LHIN and CCAC worked together to understand the current state and design the future for home and community care under the proposed new mandate. A total of 18 Functional Integration Teams (FITs) were established to explore specific functions of the two organization ranging from finance to clinical care and case management. Each FIT shared information and discussed processes, procedures and practices and, where appropriate, made recommendations to ensure operational readiness for transition.

The HNHB LHIN continues to lead the implementation of a model of care that integrates the CCAC and CSSagencies providing in-home personal support services. This "One Sector" model is directly aligned with system priorities outlined in the Ministry's Patients First strategy such as integration, consistency, capacity, quality and value. Major milestones achieved in the past year include:

- Further increased capacity in the CSS sector to maintain equitable access to PSS throughout the LHIN.
- Implementation of electronic referral solution, improving the flow of information between CCAC and CSS and enabling faster and more efficient coordination of individuals requiring in-home personal support.
- A wait list management strategy which prioritizes clients based on level of care need, as measured by standardized assessment.
- Standardized processes, such as communication materials, and policies for complaints management and phone escalation.

This work has strengthened relationships between sectors, standardized and improved consistency, enhanced the capacity of CSS agencies to provide Personal Support Services (PSS), and improved integration across all sectors including primary and acute care. Under the "One Sector" model, CSS agencies provided more than 210,000 hours of care to 2,254 individuals in 2016-17. Lessons learned will enable flexibility to adapt to pending initiatives from the ministry regarding *Patients First: A Roadmap to Strengthen Home and Community Care* (the 'roadmap').

The HNHB LHIN funds a variety of services to support caregivers including adult day programs (ADPs), companion support, educational "self-care" programs, and in-home and overnight respite. Respite providers are working together to coordinate access to these various programs and this work will continue in 2017-18. In 2016-17, the HNHB CCAC provided more than 100,000 respite hours to 1,069 caregivers with the highest needs.

The HNHB LHIN is an early adopter in implementing bundled care. The Integrated Comprehensive Care program (ICCP) model of care strengthens the integration of health care service between hospitals and home and community care. The ICCP was implemented across all acute hospitals in the HNHB LHIN in 2016-17, and has initially targeted individuals hospitalized with chronic COPD and/or Congestive Heart Failure (CHF). In 2016-17, 1,140 individuals with COPD or CHF were enrolled in this program *(Source: HNHB Integrated Decision Support Accessed May 2, 2017)*, and preliminary results demonstrated a 1.4 day reduction in hospital length of stay (LOS) and a 5% decrease in all cause readmissions within 30 days and a 9% decrease in all cause readmissions within 60 days compared to baseline *(Source: HNHB ICC 2.0 March 2017 Dashboard)*.

2016-17 also marked the third year of the PSS Wage Enhancement initiative. Now completed, this province-wide initiative enhanced the wages of Personal Support Workers (PSWs) in community organizations throughout the HNHB LHIN, allowing stability and improving the ability of HSPs to recruit individuals to join this valuable workforce.

Healthy Active Seniors

Fall-related injuries represent a significant health concern among individuals over the age of 65 and are particularly concerning for individuals living independently at home in the community *(Source: Public Health Agency of Canada, Seniors' Falls in Canada: Second Report, 2014).* Individuals experiencing a fall often suffer from devastating physical and psychological injuries which negatively impact quality of life and activities of daily living. Research has shown that progressive, tailored exercise programs contribute to improvements in strength, gait, and balance, as well as offer a chance for seniors to socialize and become more educated about key risk factors for falls.

From April 2016 to December 2016, the LHIN provided exercise and falls prevention classes to 7,858 individuals across 221 locations throughout the region.

In March 2017, the LHIN increased access to falls prevention and exercise classes with the addition of 40 new falls prevention and 19 exercise classes located across the LHIN. These classes will support programs for an additional 680 seniors through a total of 2,784 hours of class time delivered each year. Participants continue to share stories about how these classes have contributed to pain reduction, general mobility, and social connections.

'Sit to Be Fit' a Fitting Exercise Class for Seniors with Varying Abilities

"For me the greatest benefits have been a reduction of the pain in my knee and an improvement in my balance."

- Harry, program participant

"It has helped both my husband and me keep active and social. It works all the body parts to keep one moving regardless of one's challenges."

- Anne, program participant

"Participants range from the mobile and healthy to those with arthritis and mobility problems. Some exercises are done in a seated position while others are done standing up. We can choose to do them either way depending on our mobility and we only do as much as we can in relation to our physical condition. There's no pressure exerted on us."

- Aline, program participant

MLAA Performance Indicators

Figure 11: MLAA Performance Indicators

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
Performance Indicators									
1. Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	85.36%	82.10%	85.58%	89.37%	90.28%	89.02%	89.16%
The HNHB LHIN performance for this indicator declined slightly in 2016/17 compared to 2015/16, but continues to outperform the provincial average. The provincial target of 95.00% has not yet been achieved as performance consistently remains within 10% of the target each quarter. The HNHB LHIN works to identify the populations that are not seen within the provincial target and identify areas for improvement. The performance of this indicator continues to be impacted by community referrals (under target), rather than the hospital referrals (over target). Patient preference for beginning personal support services has been identified as a factor contributing to performance. A process has been implemented to follow up when the target is not met. The HNHB LHIN is continuing to expand the Collaborative Care Model (CCM) were designated LHIN-funded Assisted Living/Supportive Housing CSS agencies work as one sector for the provision of in-home PSS.									
2. Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	94.00%	93.83%	94.53%	92.67%	93.69%	94.66%	95.18%
The HNHB LHIN improved performance on this indicator in 2016/17 compared to 2015/16 and is consistently above the provincial average. HNHB LHIN met the provincial target of 95.00% during the first two quarters of 2016/17 fiscal year and remains within 10% of the target in the current quarter. The HNHB LHIN continues to monitor this population to identify variables for the population that is not served within five days. Similar to referrals for other services, those coming from the community continue to impact performance relative to the provincial target. The HNHB LHIN discusses opportunities for improving this metric using a data-driven approach.									

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
Performance Indicators									
3. 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	21 days	29.00	29.00	29.00	31.00	23.00	25.00	27.00	28.00
The HNHB LHIN performance for this indicator has slightly worsened over the 2016/17 year, continuing to not meet the provincial target of 21 days. The HNHB LHIN maintains higher performance by 2 days (on average), compared to the provincial average. Audits to better understand the reasons patients wait continue to show that some of the reasons are related to; patient/family request, difficulty contacting patient or family, internal processes resulting in delay, referral opened for a reason other than service provision, waitlists, and preplanning of service. In 2017-18 the LHIN will be exploring intake models that places first visit within days of referral.									
4. 90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	9.97	11.03	10.38	13.28	12.83	16.83	14.53
In 2016/17, the HNHB LHIN did not improve the 90th percentile ED LOS for complex patients, with a declined performance of 1.7 hours. Most hospital sites, with the exceptions of HWMH and WHGH, have seen overall increases in ED LOS for complex patients for 2016/17. Provincial performance has seen a similar trend of increased wait times, but continues to be less hours than the HNHB LHIN. Challenges for improving the metric include; increased volumes, increased acuity, increased ambulance volumes, and patient flow challenges. The Emergency Services Steering Committee continues to put an emphasis on community initiatives and admission avoidance, as well as the ALC flow strategies.									
5. 90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.23	4.15	4.50	4.55	4.68	4.57
In 2016/17, the HNHB LHIN did not meet the MLAA target of 4hrs for the non-admitted ED LOS for minor/uncomplicated patients by 34 minutes, relatively unchanged from the 2015/16 performance (33 minutes over). HNHB LHIN seasonal trends for wait times match the provincial trends during this fiscal year. Three hospitals within the LHIN are meeting the target, while five continue to have wait times approximately one hour longer (on average) than the target. Sites with the longest LOS for minor patients are continually stressed by the volume of high acuity and ambulance presentations. They continue to report challenges in relocating resources away to the minor population when the volume of high acuity patients is so much higher. Some also report that the increasing medical and social complexity of the older acute population accessing the ED involves many resources and extra efforts to develop safe care plans, therefore decreasing the resources, time and space available for minor patients. Sites improvise daily in order to meet the needs of minor/uncomplicated patients by assessing patients in rapid assessment zones, and starting nursing and physician assessments while patients are still in the waiting room.									

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
Performance Indicators									
6. Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	41.75%	38.43%	40.76%	40.17%	47.97%	47.48%	28.06%	34.87%
The HNHB LHIN performance for percent of priority 2, 3, and 4 cases completed within target for MRI scans has decreased, and continues to fall below the provincial target of 90% in 2016/17. The LHIN closely monitors the performance of sites, specifically sites completing high volumes of MRI scans. The Diagnostic Imaging Steering Committee is finalizing referral forms for MRI, expecting to implement in June 2017, which will initiate development of an e-referral and central intake. HNHB LHIN organizations now post quarterly wait time information on their websites to better inform the public. New investments for MRI in October 2016 resulted in an increase in the number of MRI cases completed in Q3 and Q4 of 2016-17.									
7. Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	77.77%	74.66%	78.31%	75.89%	74.99%	68.89%	70.90%	61.31%
The HNHB LHIN performance for percent of priority 2, 3, and 4 cases completed within target for CT scans has decreased, and continues to fall below the provincial target of 90% in 2016/17. The LHIN closely monitors the performance of sites, specifically sites completing high volumes of CT scans. The Diagnostic Imaging Steering Committee is finalizing common referral forms for CT and cardiac CT, expecting to implement in June 2017, which will initiate development of an e-referral and central intake. HNHB LHIN organizations now post quarterly wait time information on their websites to better inform the public. The LHIN completed over 13,600 more CT scans (timed and untimed) in 2016-17 over 2015-16.									
8. Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	77.89%	78.47%	75.06%	79.22%	69.19%	73.88%
The HNHB LHIN decreased in performance in this metric during the 2016/17 fiscal year, and continues to fall below the target of 90%. In the current fiscal year, the LHIN requested hospitals submit performance indicator action plans for priority indicators. One organization within HNHB continues to have an impact on the overall LHIN results, and discussions continue with the hospital to implement a wait time reduction plan. Continuous quality improvement efforts continue LHIN-wide with the work of the Orthopaedic Leadership Steering Committee, which is finalizing its 2017-2019 Orthopaedic Program Strategic Direction. The LHIN completed the second highest volumes of total hip replacements in the province in 2016-17.									
9. Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	74.50%	75.02%	72.25%	75.32%	60.86%	66.34%
The HNHB LHIN decreased in performance in this metric during the 2016/17 fiscal year, and continues to fall below the target of 90%. In the current fiscal year, the LHIN requested hospitals submit performance indicator action plans for priority indicators. One organization within HNHB continues to have an impact on the overall LHIN results, and discussions continue with the hospital to implement a wait time reduction plan. Continuous quality improvement efforts continue LHIN-wide with the work of the Orthopaedic Leadership Steering Committee, which is finalizing its 2017-2019 Orthopaedic Program Strategic Direction. . The LHIN completed the second highest volumes of total knee replacements in the province in 2016-17.									

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
Performance Indicators									
10. Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.50%	15.85%	15.16%	18.23%	16.21%	16.57%	16.17%
The HNHB LHIN has seen a reduction in the Percentage of ALC Days within 2016/17, but continues to perform higher than the target of 9.46%. Performance also remains slightly higher than the provincial average for the last 4 quarters. ALC days is influenced by the discharge of patients who have accumulated a high number of ALC days while waiting for discharge. Patients experiencing long waits for discharge is a focus for the LHIN. HNHB continues to work on a number of strategies to improve overall patient flow. These include, but are not limited to: Home First, ALC avoidance, incorporating Estimated Discharge Date into discharge practices, Hospital site-specific strategies, and continued expansion of community capacity through the HNHB Transitional Care Program and establishment of a dedicated Director of Patient flow.									
11. ALC rate	12.70%	13.70%	13.98%	15.27%	15.19%	15.78%	13.61%	14.69%	14.31%
The HNHB LHIN saw an increase in the ALC rate for 2016/17 compared to 2015/16 and is currently outside of the 10% threshold for the 12.70% target. The increased volume of patients presenting to the ED with complex medical needs and being admitted, limited social support to return home, and limited financial capacity to access alternative environments like retirement homes, are just some of the factors contributing to an increase in the ALC rate. The LHIN, however, consistently performs better than the provincial average. HNHB LHIN continues to work on a number of strategies to improve patient flow. Additional strategies include, but are not limited to: review of ALC definition and designation practices, site specific strategies, increased community capacity, and implementation and investment in the Home and Community Support Model.									
12. Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.19%	20.39%	19.81%	18.59%	18.78%	20.27%	19.51%
Compared to 2015/16, the HNHB LHIN has seen an increase in the percent of unscheduled emergency visits for mental health conditions. Performance remains approximately 3% higher than the target of 16.30%, but is slightly lower than the provincial average. The LHIN works with its MHA Advisory Committee to develop and implement strategies to reduce ED visits for this population, by identifying factors influencing repeat ED visits and plan for local quality improvement projects to reduce them.									
13. Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.01%	31.15%	31.40%	27.11%	30.10%	28.48%	28.55%
In 2016/17, the HNHB LHIN has seen improvement in the repeat unscheduled emergency visits for substance abuse conditions, compared to 2015/16. Performance continues to be outside of the target of 22.4%, but consistently better than the provincial average. The HNHB LHIN has focused on completing current and future state mapping of addictions services by sub-region, together with HSPs and community partners. The focus is to identify a coordinated and integrated pathway for addiction services and identify opportunities to optimize existing capacity, populations served, and potential service gaps/duplications.									

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
Performance Indicators									
14. Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.66%	16.51%	16.50%	16.60%	16.64%	16.60%
The HNHB LHIN performance for Readmission within 30 days for selected HIG conditions has remained relatively unchanged from 2014/15 through 2016/17, and continues to be within 10 % of the 15.5% target. This performance is similar to that of the provincial average. Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Gastrointestinal diagnoses are clinical cohorts that inflate this metric. The LHIN continues to work with its Integrated Comprehensive Care Program, Caring for MY COPD, Health Links, and Diabetes programs in an attempt to improve patient readmissions.									
2. Monitoring Indicators									
15. Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.02%	88.03%	86.82%	87.23%	77.52%	81.44%	80.45%	79.06%
The HNHB LHIN performance for priority 2, 3, and 4 cases completed within the access target for cancer surgery shows similar performance in 2016/17 compared to 2014/15 and 2015/16, despite being slightly lower than the previous year. Performance is consistently below the provincial average.									
16. Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	96.01%	95.00%	93.00%	93.00%	99.69%	99.00%	98.00%	96.00%
The HNHB LHIN continues to exceed the MLAA target of 90% for this metric in 2016/17, despite performing slightly lower than 2015/16. Performance is the same as the provincial average.									
17. Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	88.09%	85.32%	85.01%	84.78%	85.21%	87.21%	84.90%
HNHB LHIN's performance has dropped slightly in 2016/17, but remains relatively unchanged over the last 3 fiscal years. Performance matches the provincial average.									
18 (a). CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	14.00	14.00	9.00	8.00	8.00	8.00
The LHIN performance has not changed from 2015/16, and is consistently better than the provincial average.									

Indicator	Target	Provincial				LHIN			
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
Performance Indicators									
18 (b). CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	8.00	8.00	6.00	5.00	9.00	7.00
The LHIN wait times for this indicator has increased in 2016/17 compared to 2015/16, but is similar to the provincial average.									
19. Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	4.58	12.28	22.27	20.06	5.33	13.76
The HNHB LHIN performance has improved significantly in 2016/17, compared to 2014/15 and 2015/16.									
20. Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	81.88	241.40	389.33	397.01	107.48	303.32
The hospitalization rate for ambulatory care sensitive conditions has dropped by 94 cases per 100,000 in 2016/17 (YTD result), compared to 2015/16.									
21. Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	46.61%	47.46%	47.81%	47.71%	48.07%	48.17%	49.02%
The LHIN performance on this indicator improved from fiscal year 2015/16 to fiscal year 2016/17 and exceeds the provincial performance by 1.21%.									

*FY 2016/17 is based on the available data from the fiscal year (Q1-Q3, 2016/17)

**FY 2016/17 is based on the available data from the fiscal year (Q1-Q2, 2016/17)

Financial Statements and Notes

Financial statements of

Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2017

Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2017

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Independent Auditor's Report

To the Members of the Board of Directors of the
Hamilton Niagara Haldimand Brant
Local Health Integration Network

We have audited the accompanying financial statements of Hamilton Niagara Haldimand Brant Local Health Integration Network, which comprise the statements of financial position as at March 31, 2017, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the financial statements present fairly, in all material respects, the financial position of Hamilton Niagara Haldimand Brant Local Health Integration Network, as at March 31, 2017 and the results of its operations, change in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
May 31, 2017

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of financial position
as at March 31, 2017

	2017	2016
	$	$
Financial assets		
Cash	**960,321**	1,062,371
HST receivable	**56,985**	21,831
Accounts receivable - other	**21,534**	85,256
Due from Ministry of Health and Long-Term Care ("MOHLTC") transfer payments to Health Service Providers ("HSPs") (Note 9)	**26,181,852**	31,249,618
	27,220,692	32,419,076
Liabilities		
Accounts payable and accrued liabilities	**337,073**	262,301
Due to the MOHLTC (Note 3b)	**709,094**	913,720
Due to Health Service Providers ("HSPs") (Note 9)	**26,181,852**	31,249,618
Due to the LHIN Shared Services Office (Note 4)	**-**	2,601
Deferred capital contributions (Note 5)	**73,636**	21,659
	27,301,655	32,449,899
Commitments (Note 6)		
Net debt	**(80,963)**	(30,823)
Non-financial assets		
Prepaid expenses	**7,327**	9,164
Tangible capital assets (Note 7)	**73,636**	21,659
Accumulated surplus	**-**	-

Approved by the Board

_____ Director

_____ Director

The accompanying notes to the financial statements are an integral part of these financial statements.

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of operations
year ended March 31, 2017

	Budget (Note 8)	2017 Actual	2016 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSPs transfer payments (Note 9)	2,932,446,000	3,019,516,021	2,941,067,069
Operations of LHIN	4,884,366	4,793,538	4,599,809
Project Initiatives			
Enabling Technologies for Integration Project Management Office ("ETI PMO") (Note 4)	510,000	510,000	510,000
ER/ALC Performance Lead	-	100,000	100,000
French Language Services	-	106,000	106,000
French Language Planning Entity	-	411,693	411,693
Emergency Dept LHIN LEAD	-	75,000	75,000
Critical Care LHIN LEAD	-	75,000	75,000
Aboriginal Planning	37,500	37,500	37,500
Primary Care LHIN Lead	-	75,000	75,000
Diabetes Education	-	824,475	824,475
Patients First Transition Planning and Implementation	-	180,000	-
Amortization of deferred capital contributions (Note 5)	-	38,850	38,662
	2,937,877,866	3,026,743,077	2,947,920,208
Funding repayable to the MOHLTC (Note 3a)	-	(521,005)	(188,089)
	2,937,877,866	3,026,222,072	2,947,732,119
Expenses			
Transfer payments to HSPs (Note 9)	2,932,446,000	3,019,516,021	2,941,067,069
General and administrative (Note 11)	4,884,366	4,313,067	4,452,413
Project Initiatives (Note 10)			
ETI PMO	510,000	510,000	510,000
ER/ALC Performance Lead	-	100,000	100,000
French Language Services	-	106,000	106,000
French Language Planning Entity	-	411,693	411,693
Emergency Dept LHIN LEAD	-	73,316	72,969
Critical Care LHIN LEAD	-	75,000	75,000
Aboriginal Planning	37,500	37,500	37,500
Primary Care LHIN Lead	-	75,000	75,000
Diabetes Education	-	824,475	824,475
Patients First Transition Planning and Implementation	-	180,000	-
	2,937,877,866	3,026,222,072	2,947,732,119
Annual surplus and closing accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of change in net debt
year ended March 31, 2017

	Budget (Note 8)	2017 Actual	2016 Actual
	$	$	$
Annual surplus	-	-	-
Change in prepaid expenses	-	**1,837**	36,045
Acquisition of tangible capital assets	-	**(90,827)**	(16,363)
Amortization of tangible capital assets	-	**38,850**	38,662
Increase in net debt	-	**(50,140)**	58,344
Net debt, beginning of year	-	**(30,823)**	(89,167)
Net debt, end of year	-	**(80,963)**	(30,823)

The accompanying notes to the financial statements are an integral part of these financial statements.

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of cash flows
year ended March 31, 2017

	2017	2016
	$	$
Operating transactions		
Annual surplus	-	-
Add items not affecting cash		
Amortization of capital assets	38,850	38,662
Less items not affecting cash		
Amortization of deferred capital contributions	(38,850)	(38,662)
Changes in non-cash operating items		
Accounts receivable - other	63,722	(85,076)
HST receivable	(35,154)	3,535
Due from MOHLTC to HSPs	5,067,766	(8,795,774)
Accounts payable and accrued liabilities	74,772	48,345
Due to the MOHLTC	(204,626)	188,089
HSPs from MOHLTC	(5,067,766)	8,795,774
LHIN Shared Services Office	(2,601)	2,520
Prepaid expenses	1,837	36,045
	(102,050)	193,458
Capital investment		
Acquisition of tangible capital assets	(90,827)	(16,363)
Financing transaction		
Capital contributions received	90,827	16,363
Net change in cash	(102,050)	193,458
Cash, beginning of year	1,062,371	868,913
Cash, end of year	960,321	1,062,371

The accompanying notes to the financial statements are an integral part of these financial statements.

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Notes to the financial statements
March 31, 2017

1. Description of business

The Hamilton Niagara Haldimand Brant Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Counties of Hamilton, Niagara, Haldimand, Brant, most of the County of Norfolk and the City of Burlington. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry - LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC"). These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount, the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed HSPs in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2017.

The LHIN has also entered into an Accountability Agreement with the MOHLTC, which provides the framework for LHIN accountabilities and activities.

The LHIN statements do not include any MOHTLC managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian Public Sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

2. **Significant *accounting policies (continued)***

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year. Infrastructure/web development costs are included with computer equipment for accounting and reporting purposes.

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

2. Significant accounting policies (continued)

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimate and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Funding received	Eligible expenses	2017 Excess funding	2016 Excess funding
	$	$	$	$
Transfer payments to HSPs	3,019,516,021	3,019,516,021	-	-
LHIN operations	4,832,388	4,313,067	519,321	186,058
ETI PMO	510,000	510,000	-	-
French Language Planning Entity	411,693	411,693	-	-
French Language Services	106,000	106,000	-	-
ER/ALC Performance Lead	100,000	100,000	-	-
Emergency Dept. LHIN LEAD	75,000	73,316	1,684	2,031
Critical Care LHIN LEAD	75,000	75,000	-	-
Primary Care Lead	75,000	75,000	-	-
Aboriginal Planning	37,500	37,500	-	-
Diabetes Education	824,475	824,475	-	
Patients First Transition Planning and Implementation	180,000	180,000	-	-
	3,026,743,077	3,026,222,072	521,005	188,089

b) The amount due to the MOHLTC at March 31, 2017 is made up as follows:

	2017	2016
	$	$
Due to MOHLTC, beginning of year	913,720	725,631
Funding repayable related to current year activities to the MOHLTC (Note 3a)	521,005	188,089
Amount recovered by the MOHLTC during the year	(725,631)	-
Due to MOHLTC, end of year	709,094	913,720

4. **Related party transactions**

LHIN Shared Service Office, LHIN Collaborative and Health Shared Services Ontario

The LHIN Shared Services Office (the "LSSO") was a division of the Toronto Central LHIN and was subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs was responsible for providing services to all LHINs. The full costs of providing these services was billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN as at February 28, 2017 were recorded as a receivable (payable) from (to) the LSSO. This was done pursuant to the shared service agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC was to support the LHINs in fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system; their role as system manager; where appropriate, the consistent implementation of provincial strategy and initiatives; and the identification and dissemination of best practices. LHINC was a LHIN-led organization and accountable to the LHINs. LHINC was funded by the LHINs with support from the MOHLTC.

Effective February 28, 2017 pursuant to a transfer agreement between Toronto Central LHIN and Health Service Shared Services Ontario (HSSO) responsibility for the shared services previously provided by the LSSO and the LHINC was transferred to HSSO. HSSO is a provincial agency established January 1, 2017 by O. Reg. 456/16 made under LHSIA with objects to provide shared services to LHINs in areas that include human resources management, logistics, finance and administration and procurement. HSSO as a provincial agency is subject to legislation, policies and directives of the Government of Ontario and the Memorandum of Understanding between HSSO and the Minister of Health and Long Term Care.

Enabling Technologies for Integration Project Management Office

Effective January 31, 2014, the LHIN entered into an agreement with South West, Erie St. Clair and Waterloo Wellington LHIN's (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received funding from the South West LHIN of $510,000.

5. **Deferred capital contributions**

	2017	2016
	$	$
Balance, beginning of year	**21,659**	43,958
Capital contributions received during the year	**90,827**	16,363
Amortization for the year	**(38,850)**	(38,662)
Balance, end of year	**73,636**	21,659

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease *renewals are likely. Minimum lease payments due under existing leases are as follows:*

	$
2018	172,786
2019	71,786

The LHIN also has funding commitments to HSPs associated with accountability agreements. The actual amounts which will ultimately be paid are contingent upon LHIN funding received from MOHLTC.

7. Tangible capital assets

	Cost	Accumulated amortization	2017 Net book value	2016 Net book value
	$	$	$	$
Office, equipment, furniture and fixtures	494,740	482,884	11,856	16,516
Computer equipment	339,734	277,954	61,780	5,143
	834,474	760,838	73,636	21,659

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of operations reflect the initial budget at April 1, 2016. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year.

The final HSP funding budget of $3,019,516,021 is derived as follows:

	$
Initial budget	2,932,446,000
Adjustment due to announcements made during the year	87,070,021
Final budget	3,019,516,021

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Adjustment due to announcements made during the year	87,070,021
Final budget	3,019,516,021

8. Budget figures (continued)

The final LHIN general and administrative budget of $7,279,434 is derived as follows:

	$
Initial budget	
LHIN operations	**4,884,366**
ETI PMO	**510,000**
Aboriginal Planning	**37,500**
Additional funding received during the year for:	
French Language Planning Entity	**411,693**
French Language Services Coordinator	**106,000**
ER\ALC Performance Lead	**100,000**
Emergency Dept. LHIN LEAD	**75,000**
Critical Care LHIN LEAD	**75,000**
Primary Care Lead	**75,000**
Diabetes Education	**824,875**
Patients First	**180,000**
Final budget	7,279,434

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $3,019,516,021 (2016 - $2,941,067,069) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2017 as follows:

	2017	2016
	$	$
Operations of hospitals	**1,979,076,717**	1,933,929,144
Grants to compensate for municipal taxation - public hospitals	**462,750**	462,000
Long-term care homes	**497,028,368**	487,760,279
Community care access centres	**328,666,580**	311,792,567
Community support services	**56,659,208**	52,497,726
Acquired brain injury	**7,655,039**	7,549,178
Assisted living services in supportive housing	**35,983,893**	35,752,550
Community health centres	**29,545,184**	29,277,055
Community mental health addictions program	**84,438,282**	82,046,570
	3,019,516,021	2,941,067,069

The LHIN receives money from the MOHLTC which it in turn allocates to the HSPs. As of March 31, 2017 an amount of $26,181,852 (2016 - $31,249,618) was payable to the HSPs. This amount has been reflected as revenue and expenses within the LHIN's operations and is included above.

10. Project initiatives

The LHIN received funds for various project initiatives listed in the Statement of Operations. The following table classifies the initiatives expenses by object:

	2017	2016
	$	$
Salaries and benefits	**1,045,859**	902,803
Professional services	**1,246,750**	1,206,825
Shared services	**34,000**	36,000
Occupancy	**33,000**	37,000
Supplies	**10,173**	10,790
Mail, courier and telecommunications	**15,888**	10,438
Other	**7,315**	8,781
	2,392,984	2,212,637

Diabetes strategy operational expenses included in the project initiative expenses above are as follows:

	Actual 2017	Actual 2016
	$	$
Salaries and benefits	**753,060**	717,701
Others	**71,415**	106,774
	824,475	824,475

11. Expenses by object

The Statement of operations presents the expenses by function. The following classifies general and administrative expenses by object:

	2017	2016
	$	$
Salaries and benefits	**3,323,135**	3,421,040
Board Chair per diems	**33,250**	26,425
Directors' per diems	**45,400**	32,559
Board expenses	**19,595**	9,654
Travel	**16,428**	19,164
Consulting services	**68,482**	127,301
Community forums and communication	**55,586**	43,340
Supplies, equipment, maintenance, other	**64,225**	56,942
Occupancy costs	**299,044**	284,162
Amortization	**38,850**	38,662
Shared services	**349,073**	393,164
	4,313,067	4,452,413

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of 40 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2017 was $348,047 (2016 - $330,651) for current service costs and is included as an expense in the Statement of operations. The last actuarial valuation was completed for the plan as at December 31, 2016. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act*, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

14. Subsequent event

On April 3, 2017 the Minister of Health and Long-Term Care made an order under the provisions of the Local Health System Integration Act, 2006, as amended by the Patients First Act, 2016 to require the transfer of all assets, liabilities, rights and obligations of the Hamilton Niagara Haldimand Brant Community Care Access Centre the (CCAC), to the LHIN, including the transfer of all employess of the CCAC.

Effective May 10, 2017 the LHIN assumed the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

The actual financial impact of the transition is not currently known, however it is expected that assets assumed will equal liabilities assumed. Additionally there are no significant commitments being assumed as a result of the transition.

Board Members

(as of March 31, 2017)

Janine van den Heuvel
Chair

Mervin Witter
Vice Chair

Laurie Ryan-Hill
Vice Chair

Bill Thompson
Board Member

Dominic Ventresca
Board Member

Madhuri Ramakrishnan
Board Member

Paul Armstrong
Board Member

Saqib Cheema
Board Member

William Chopp
Board Member

Senior Staff Member

Donna Cripps
Chief Executive Officer

On behalf of the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to submit this Annual Report for the period ended March 31, 2017.

Janine van den Heuvel
Chair, Board of Directors

Bill Thompson
Vice Chair*, Board of Directors
**effective May 31, 2017*

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